## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 19001. Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Deeth June 2000 Ina Alva Simmons 10:45 pm. 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth LongView Nursing Home Manchester Carroll 8. Dete of Birth (Month, Pay, Year) 4 5. Social Security Number 212-01-8747 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In yrs. last birthday) 1□M 2□F Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 No Carroll Hampstead 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1901 Boog Rd. 21074 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Reca - American Indian, Black, Whita, atc. 11 Merital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify Specify: White 3 H Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) James Keenan Amelia Keenan Masenhimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara Parthree - daughter P.O. Box 297, Manchester, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Snydersburg Church Cem. June 16,2000 Snydersburg, Md. 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102 Hute Echald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) e Cancel Ova Due to (or as a consequence of). A. D Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): ements Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 N NO 3 Probably 4 Unknown 24b. Wara autopsy findings evailable prior to completion of cause of death? 24e. Wes an eutopsy performed? 1 Yes 2 No 1 Yes 2 DHG 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 LNG 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation

The law requires that the deeth certificets be executed physician end the burial-transit Physician/Medical US0 88 signed by the aid be detached for þ Completed page 2 has director, Be 2 After this funeral Certification: the

**Physician** 

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Mair Department of Health and Mental Hygiens. Important: If flem 27 is marked other than "natural", or farms 23a or 28a-f stemy injury or other trsummits event, the Medical Examination and page.

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with the Maryland

Division of Vitai Records, P.O. Box 68760. or Attending Physician: after death. filled in by

To the Hospital or within 24 hours af To the Funeral D completely filled I

State Registrar

Kaman 31. Date filed (Month, Day, Year) JUN 1 5 2000

29b. Signeture and We of certified

2 ☐ Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

6 Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kan eria

Que

419F Malcola 32. Registrer's Signature

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

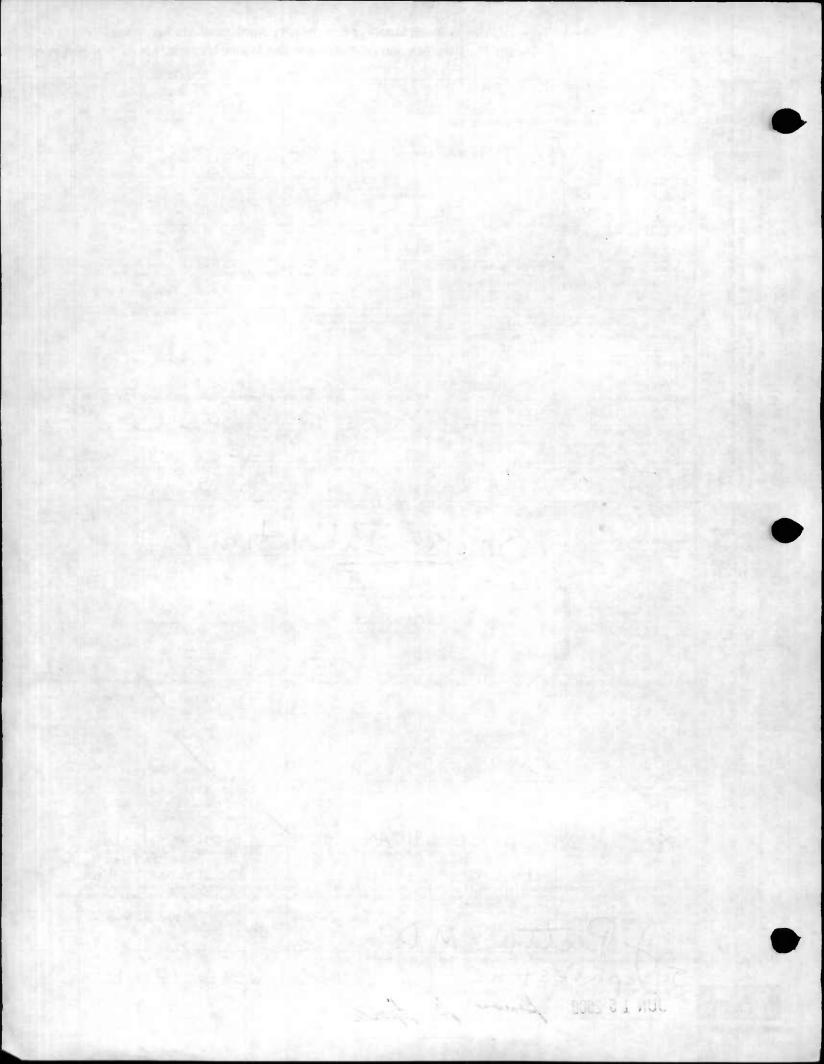
28f. Location (Street end Number or Rural Routa Number, City or Town, State)

Dr. Westmisster MD

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State of Maryland / Department of Health and Mental Hygiene 9003 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** 2000 1:30AH TINANOFF ROSALIE JUNE /Medical 4c. County of Death 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Baltimore LOCH PAVEN CTZ-GENESIS ELDERCARE 7. Age (In yrs. last birthday) If Under 1 Months 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Deys 10 M 20 F 219 16 5985 76 MARCH 14, 1924 Director MD Usual Residence of Decedent with the Menyland 10a. Stata 10b. County 10c. City, Town or Location t 0d. Inside City Limits or items 23a or 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Meryla administration of Heelth end Mental Hygiene.
Orfant: if Hear 27 is marked other than "natural", or Hems 23a or 28a-f show injury or other traumatic avent, if a heaces Examine must be notified. 1 Tes 2 No Funeral Director 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Giva 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Be Completed by 3 Widowed 4 ☐ Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Rite r's Name /First Middle Last 18. Mother's Name (First, Middle, Maiden Sumame) 20 t9a, informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other pla permit. Pages 1 and 2 Department of Heelth e Important: If Itsm 27 is sny injury or other tra 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2000 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral 22a. Pert1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** immediate Causa (Final disease or condition resulting in death) /Medical Examiner Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last for use es the burial-tran Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760. ettending physician Physician/Medical Dua to (or as a consequence of): signed by the ell Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h Did tobacco use contributs to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 Wunknown by 24b. Were autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? page 2 should Completed certificate hes 1 Yes 2 10 No 1 Yes 2 No nepital or Attending Physician: The hours after death.

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2000 Streeegh RIPURANENI 30. Nema and address of person who completed ceuse of death (Item 23a) (Type, Print) 560 ( Loch Rauer Black ( Balt) 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JUN 1 5 2000 Registrar ours

DHMH 16 Rev 6/95

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## Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last, 2. Date of Deeth 3. Time of Death Month 2000 06 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Villa St. Michaels Nursing Home Baltimore N/A If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth Feb. 16, 1957 5. Social Security Number 212-72-8203 6. Sex 1 → M 2 □ F 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) Months Days 43 Yrs. Usual Residence of Decedent 10a. Slete 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1⊠Yes 2□No 10f. Zip Code 21215 10g. Citizen of What Country? 10e. Street and Number 4800 Seton Drive United States 14. Race - American Indian Black, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Never Worked N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Clarence Tasker, Sr. Annie Marie Snowden 19a. Informant's Name/Reletionship (Type, Print) Emma McDaniel/ Sister 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 120 Obery Ct. Annapolis, MD 21401 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel Irom State Chesapeake Crematory, Inc.6/13/00 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD aura C. Hardesty 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LIFE TIME disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequença of):

or Attending Physician: The law requires that the death certificate be executed ettending physician and for use as the bunal-transit Division of Vital Records, P.O. Box 68760, signed by the e After 1 ours after death. To the Hospital o within 24 hours af To the Funeral Di completely filled is

**Physician** 

/Medical

Examiner

Directo

Funeral

þ

Completed

To Be

Examiner

**Funeral** 

Director

Name 23s or 28s-f

I Health and Mental Hygiene. Item 27 is merked other than "naturel", or Neme 23s or 23s-f other traumatic event, the Medical Examinar must be notifie

6

**Physician** /Medical

**Examiner** 

permit. Pages 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Important if Item 27 is merked other than "natural" or he

Baltimore, Maryland 21215-0020

the Marylar

Part II. Other significant conditions con	ntributing to death but not rea	sulting in the underlying	cause given in Part I.	23b. Did 1obacco use co	ontribute to the cause of death?  3 Probably 4 Unknow		
		44178		24a. Wes an autopsy performed?	24b. Were eutopsy lindings available prior to completion of cause of death?		
				12 Yes 2□No	1 ☐ Yes 20 No		
25. Was case referred to medical examiner?	Hospital:		Other	eath (Check only one)			
10 165 42 110	1 LJ Inpatient 2 L	ER/Outpatient 3 0	OOA Wursing		1 1 21		
27. Menner of Death  1 Netural 5 Pending  2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	rred		
3 Suicide 6 Could not be determined	28e. Pleca of Injury - At h building, etc. (Speci	nome, larm, street, lacto	28f. Location (Street and Number City or Town, State)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)			

06-12-2000

ve Ste301, Balt. m. 92/21/1

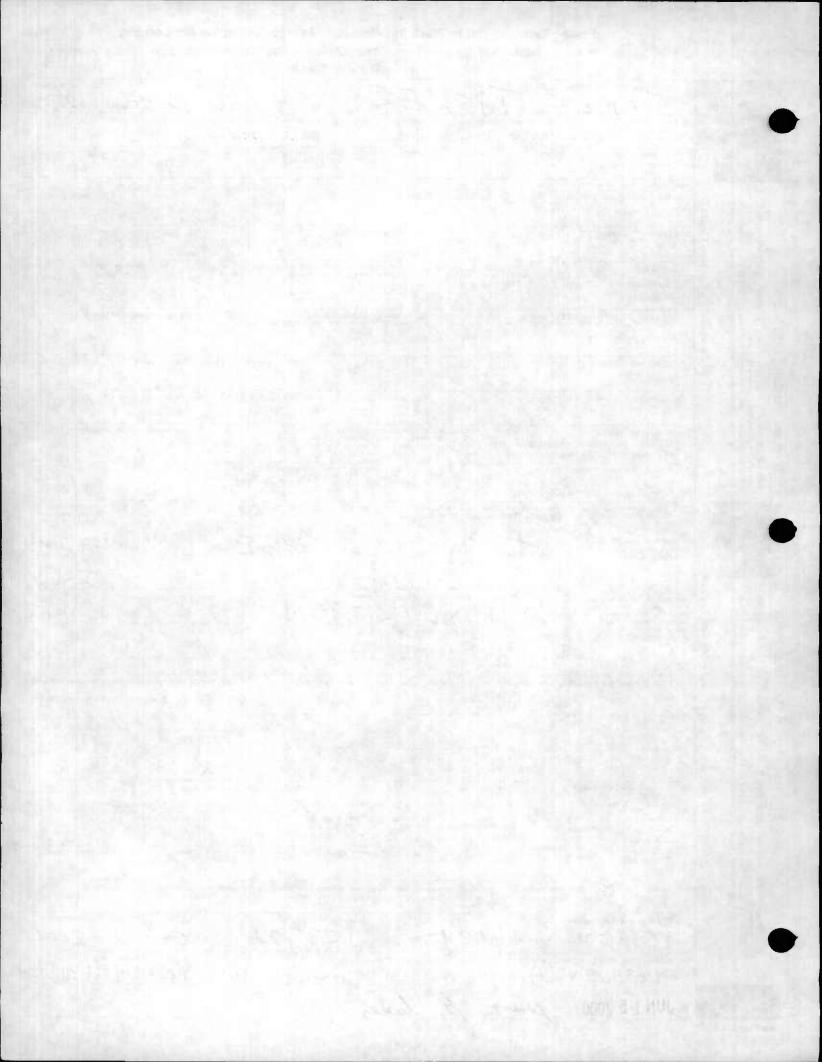
**DHMH 16 Rev 6/95** 

State Registrar 31. Date filed (Month, Day, Year) JUN 1 5 2000

OLUSEGUN

32. Registrer's Signe

**ORIGINAL** 



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death JUNE 12, 2000 G. TROUT 5:30 PM **OLGA** 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number)

**Physician** /Medical **Examiner** 

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland "naturel", or items 23s or 28s-f show diesi Examiner must be notified at

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier

29b. Signeture and title-of certified

31. Date filed (Month, Day, Year)

JUN 1 5 2000

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death.

To the E4 hours after death.

To the F4 hours after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunkel-transit

Division of Vital Records, P.O. Box 68760,

725 MI	. WILSON	LANE #201			BALTIMO	RE	BA	LTIMORE
5. Social Security 212-52- Usuel Residence	-1125	ex 7. Age (In yrs.		hs Deys	If Under 24 Hi Hours Mi		rth ay, Year) 2,1900	9. Birthplece (State or Foreign Country)  N.Y.
10a. Stete	10b. County  BALTIMO		ty, Town or Location	ORE				10d. Inside City Limits 1 ☐ Yes 2 💥 No
MD  10e. Street and N  725 MT  11. Meritel Status 1 □ Never Me 3 ☑ Widowed	umber	LANE #201	10f.	Zip Code	21208		10g. Citizen of	What Country?
	rried 2 Married 4 Divorced	12. Wes Decedent Ever in to Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	If Yes, s	ecedent of H specify Cubs s 2X No	lispanic Origin? an, Mexican, Pue Specify:	Specify Yes or No irto Ricen, etc.)		ce - American Indien, ck, White, etc. cy: WHITE
Elementary/Sec	15. Decedent's Ed ecify only highest gra- condery (0-12)		life. DO NO	work done	during most of w	orking		usiness/Industry
17. Father's Name	e (First, Middle, Last)		SECRET	ARY	18 Mother's N	eme (First, Middle	-	L GOVERNMENT
JOSEPH		ΚV	JFMAN		FRANCE		.,	KERNGOOD
	Neme/Reletionship (7		1	ress (Street			per, City or Town	State, Zip Code)
	B. TROUT							RE, MD 21210
20a. Method of Di		20b. Removel from State	Plece of Disposition (cometery, cremetory) TIMORE HER	Neme of or other place	ce)	Date	20c. Location	- City or Town, Stete
De Ja	uneral Servicert icen  U QU  The disease, or confi	DUVIZ	8900	REIST		ROAD -	PIKESVII	Approximete
Immediate Cause disease or condit resulting in death	e (Finei	/ 1						interval Between Onset and Deeth
Sequentially list of any, leading to cause. Enter Uni		Coy(1)	phalmono	off:	inve			
Sequentially list of any, leeding to ceuse. Enter Und Cause (Disease of	Immediate derlying	Due to (	or es e consequence	of):				
thet initieted ever resulting in death	nts	Due to (d	or es e consequence	of):		dist.		
Cause (Disease of their initiated ever resulting in death	There is	entributing to death but not res	sulting in the underlyir	ng ceuse giv	en in Pert I.			ontribute to the cause of death?
	11				1 80		s an autopsy ormed?	24b. Were autopsy findings eveileble prior to completion of cause of death?
						1 🗆	Yes 2 No	1 ☐ Yes 2 ☐ No
25. Wes case refe exeminer?	erred to medical					eath (Check only	one)	
1 Yes 2 €	2100	Hospitai: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Oth	er: 4 Nursing	Home 5 Res	idence 8 🗆 Ot	her (Specify)
27. Manner of Dec 1 Neturel 2 Accident	5 Pending Investigation		28b. Time of Injury	28c. Injur Wor 1	y at k? Yes 2 □ No	28d. Describe	how injury occu	rred
3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, ferm, street, fed fy)	ctory, office			(Street and Num own, Stete)	ber or Rurel Route Number,

State

Registrar

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated.

29c. License number 5 7 0 3 3 9

29d. Date signed (Month, Dey, Year)

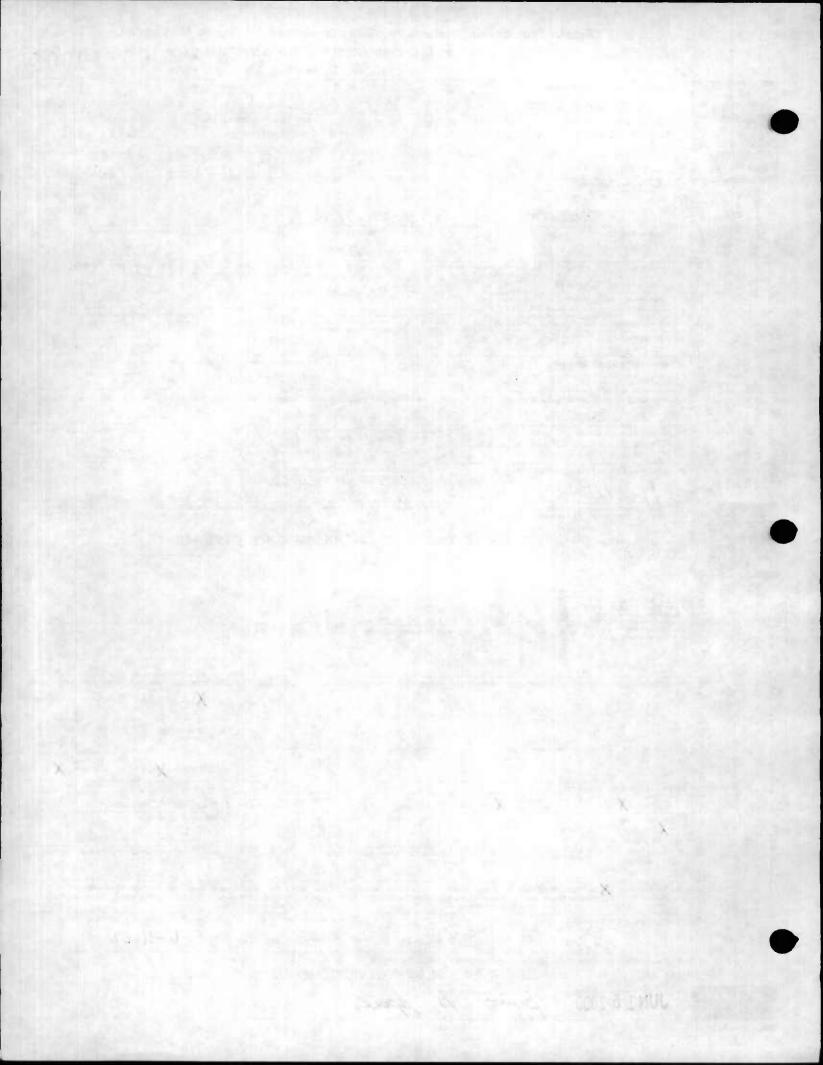
2005 3 1 MUE

James

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MARY LORESTA VOCAGELESIN  Sacial Joseph Medical Center  Tovision  Saint Joseph Medical Center  Tovision  Social Mary Interest Joseph Medical Center  Tovision  Tovis	Dhambaia	1. Decedent's Neme (First, Middle,	Last)				2. Date of Deat Month		3. Time of Death			
4s Facility Name of prior isotrations, you setted and number of the prior of the pr		MARY LORETTA	OEGELEIN				JUNE					
South Security Number   Color   Colo				Tenter								
216-OL-9438  State   10.0 County   10.0 Co					If Under 1 Yeer							
Top   State   Top   State   Top   State   Top   State   Top   State   State   Top   State	_	216-01-8488			Months Deys		(Month, Dey, 1/23/16	Year)				
The Street and Number Country?  100. Top Code  105. Citizen of What Country?  105. See and Number Country?  106. See and Number Country?  106. See and Number Country?  107. See and Number Country?  108. Informatic Number Country?  108. Informatic Number Country?  108. Informatic Number Country?  108. Informatic Number Country?  109. Number See and Number Country	WO W			10c. City, Town or Lo	ocation				10d. inside City Lim			
1.1   1.556 MUSSULA ROAD   1.1   Martial Status   1.2   Was Decedent Ever in U.S.   1.3   Was Decedent of Fisquence Origin? (Speatly Year on No.   1.4   Pages American Indian, 96.2   No.   1.1   Year Can No.   1.1   Y	the ctor	MD BALT:	MORE	TOWSO	ON				1 □ Yas 2 □X			
3 M Wiskowski 4 Choncost   Specify   Specify   Specify   WHITE    10	23s or 28	7.11.1.0011112.3412.2.7.7	DAD			5						
18. Mother's Name (Print, Modifies, Last)   18. Mother's Name (Print)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number of Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   18. Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip		1 Nevar Married 2 Merrie	Armed Forces? 1 ☐ Yas 2 N If Yes, Give	0			pecify Yes or No- Ricen, etc.)	Bleck	k, White, etc.			
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## SE21 LOCH RAVEN BLVD. TOWSON, MD 21286    Complete Course (Fine)	injury	1					6/14/200	O ELKR	IDGE, MD			
Medical Team Medical Team (See and Deskin Medical Team (See and Deskin Medical Team) (See and De	any and	Mother 1	1. Slay	TH	IE JOHNSO	N FUENRAL			21286			
Christian   Table   Cause (Fine)	1 23	23a Pinta. Entar tha disaase, or contact, or heart feilura. List or	omplications that caused nly one cause on bach lin						Interval Between			
disease or condition southing in deelin)  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions, if any, liseding to immediate cause (of cause (Disease or influry) that initieted events resulting in death) Last  Due to (or es a consequence of):  1			,						Onset and Deeth			
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Course (Disease or influry that inhibited events rasulting in death) Last  Due to (or es a consequence of):  Due to (or es a consequence of):  The course of	al-tra	Sequenticity list conditions, if any, leading to immadiate	1	Due to (or es a consequence of):								
Part II. Other afgnificant conditions contributing to death but not resulting in the undarlying ceuse given in Pert I.    23b. Did tobacco use contributs to the cause of death of the undarlying ceuse given in Pert I.   1		Cause (Disease or injury that initiated events	c	C								
25. Was casa raferred to medicel examiner?  1	D. C.	rasulting in death) Last		Due to (or es a consec	(uence of):							
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27. Manner of Death 1 Neturel 2 Accident 3 Suicide 4 Homicida 28e. Plece of injury - At homa, ferm, street, fectory, office 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how inju	stor. I					26. Place of Date	ath (Chack only on					
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signeture end title of certifier  29b. Signeture end title of certifier  29c. License number  29d. Dete signed (Month, Dey, Year)			Hospital: 1 Inpatie	nt 2 ER/Outpetie	nt 3 DOA	her: 4 Nursing H	lome 5 Reside	ence 8 Oth	er (Specify)			
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signeture end title of certifier  29b. Signeture end title of certifier  29c. License number  29d. Dete signed (Month, Dey, Year)	ftar ti nara on:	1 Neturel 5 ☐ Panding		Year) 28b. Tima o Injury			28d. Describe ho	ow injury occurr	ed			
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signeture end title of certifiar  29c. License number  29c. License number  29d. Dete signed (Month, Dey, Year)	M Directo	determin	ed 286. Plece of inju	ry - At homa, ferm, sti . (Specify)	reet, fectory, office		28i, Location (Si City or Town	treet and Numb n, Stete)	er or Rural Route Number,			
Dat Chos D 30263 6-11-00	Funera etely fills dicai	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of taminer: On the basis of and menner ste	f my knowledge, deet examination and/or in ted.	h occurred at the t vastigation, in my	ime, date end plece opinion, deeth occu	, end due to tha corred at tha time, d	ausa(s) and ma ata end place, a	nnar as stated. and due to the cause(s)			
Dat Chos D 30263 6-11-00	·	29b. Signeture end title of certifiar	1 1	ina	29c. Licen	se number	2	9d. Dete signed	d (Month, Dey, Year)			
30. Neme end address of person who completed cause of deeth (Itam 23a) (Type, Print)	Toth			1////				2 2 4				
	Toth	na	1100	Choo	D 30	263		6-11-	00			



### Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** June JOHN LUTHER WILLIAM'S 2000 unknown 4c. County of Death /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** 4100 ERDMAN AVE. BALTIMORE N/A If Undar 1 Year Birthplace (State or Foreign Country) If Undar 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Months Deys Hours 1₩ 2□F 219-40-1291 56 Yes MAY 29, 2000 S.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits XX Yes 2 □ No MD N/A BALTIMORE Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4100 ERDMAN AVE. 21213 U.S.A Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Year or Datas: 1 Never Married 2XXMarried 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 TH GRADE N/A DRIVER BEVERAGE CORP. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be HERBERT WILLIAMS JR. 2 GLADYS McLAURIA 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 107 E. BELVEDERE BALTO. MD 21212 JANIE ABMED 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 14 Buriat 2 ☐ Cremetion 3 ☐ Removel from State 6/20/00 WOODLAWN CEMETERY BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility BETTS FUNERAL HOME 21. Signature of Funeral Service Licensee PATRICIA BETTS PER D.V.R. 1129 N CAROLINE ST. BALTIMORE, MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intervat Between Onset and Death immediate Cause (Final LYNG disease or condition resulting in death) Due to (or as a consequanca of): Examiner Sequentially list conditions, if any, teading to immediate causa. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 62 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy parformed? Completed completion of causa of death? 1 Yes No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Othar: 4 Nursing Home Seridence 8 Other (Specify) Injury at 28d. Describe how Injury occurred 1 Yes 2 No Hospitel: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Tima of 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? Hatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Contifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one)

To the Hosp within 24 hou To the Fune completely fi

**DHMH 16 Rev 6/95** 

**Funeral** 

Director

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Physician /Medical

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24 hours after deat Funeral Director:

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital Physician:

Division or Attanding

Baltimore, Maryland 21215-0020

State Registrar

WAlken STANLE 31. Date filed (Month, Day, Year, JUN 1 5 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

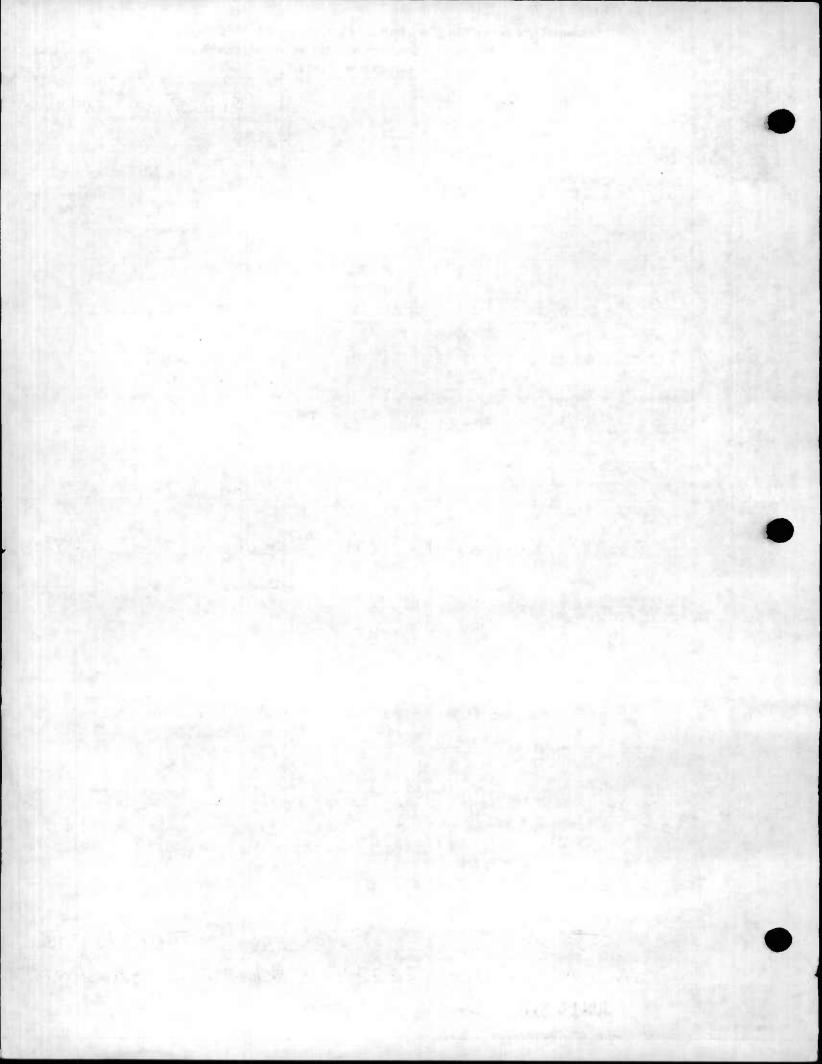
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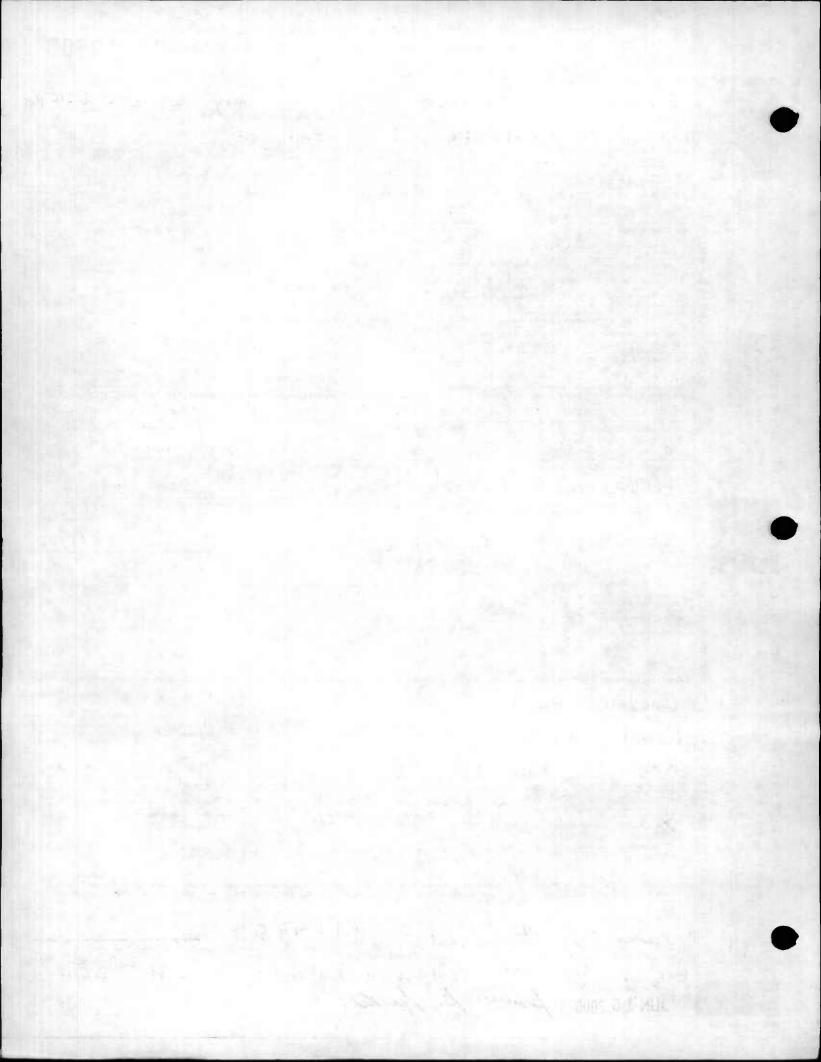
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State of Maryland / Department of Health and Mental Hygiene 1 9 0 8

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			Medical Cel	ge (In yrs. last bir	thday) If Under 1 Yas	BAHIMOR ar If Under 24 Hrs.		,	A Piethole	one (State or Femilia		
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her death with the Marylish Herne 23s or 23s-f show ther must be notified at	ral Dir	10e. Street and Number	lway		10f. Zip Code 2121			0g. Citizen of W USA	mat Count	ry r		
_ b #8	by	11. Marital Status  1 □ Never Married 2 □ Married 3 및 Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Ves 2 If Yes, Give Year or Detes	?   No	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	pecify Yes or No- Pican, etc.)		- America c, Whita, e	tc.		
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d be set to se o	o Be	Cleveland		Walker		Alice		Par	ker			
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CZNA			ker		229 N. B							
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Page Page		4 Donation 5 Other (Spec		Garri	son Fore	st VA Ce	m.06-05	-2000	Owin	gs Mills		
Ball Depart	9008	21. Signatura of Funeral Service Lic	Holla	nd	22. Name and Add	ress of Facility Ba arch FH	ltimore 1101 E.	_				
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D 5	line -	b										
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DIVISION To the Hospital or Attendin within 24 hours after dasth. To the Funeral Director: Aft completely filled in by the fun	edicai	29a. Certifier (Check only one)  Check only 2 Medical Exit	hyetctan: To the besi miner: On the besis and manners	of examination en	, deeth occurred at the For investigation, in my	time, date and place, opinion, death occur	and due to the co red et the time, do	use(s) end mar ate and place, e	nner as sta nd due to	ited. the cause(s)		
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241		30. Name and address of person who	completed cause of	death (Item 23a) (		1 1	1.	" 4	Baltin	org mo.		
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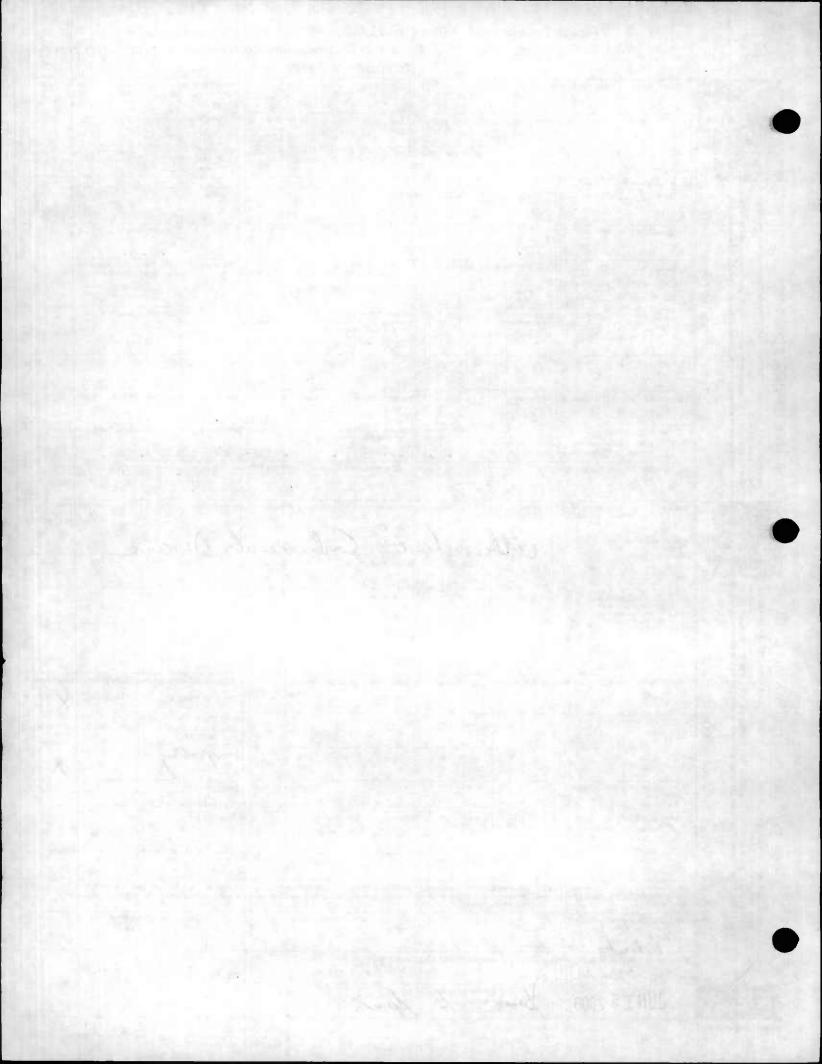


00-3225-510 William Walker

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State of Maryland / Department of Health and Mental Hygiene 00 19009

<b>/</b> ₩					Cei	rtifica	te of	Death			Reg. No.		1 2 0 0 2
Physician	THE SECTION OF THE PARTY OF THE	Decedent's Name (First, Middle, Last)     WILLIAM WALKER								2. Date of De Month	ath Day	Year	3. Time of Death
/Medical	II I LUL									June		000	04:28 A.N
Examiner	4a Facility Name (If not Institution 2204 Whitt	_		nber)						cation of Deati	4c. Count	y of Death	
Europol	5. Social Security Number	6. Sex	enue	7. Age (In yrs.	last birthday)	if Unde	er 1 Year	If Under 2	timo	8. Date of Birth (Month, Day, Year) 7-6-1942		Birthplece (State or Foreig Country)	
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9	Usual Residence of Decedent			140.00									
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P. Fu		larried	Armed Fo 1 Yes If Yes, Giv	2 No		ir ves, spi 1 ☐ Yes		an, Mexican, Specify:	Pueno	Hican, etc.)		ck, White,	
d by		bec	Year or D	ates:				100			Speci	*BLA	JK
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and the Man	Elementary/Secondery (0-1)	2)	College (1-40f 5+)			a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) SELF EMPLOYED				CARP		ENTE	R
Hand Hand		lle, Last)							r's Name	(First, Middle	Maiden Suma		
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) time 8	29b. Signature and title of cert	MI	pleted éaus	a of death (Ital	m 23a) (Type,	Print)	0.	С. М.	E.		June	10,	
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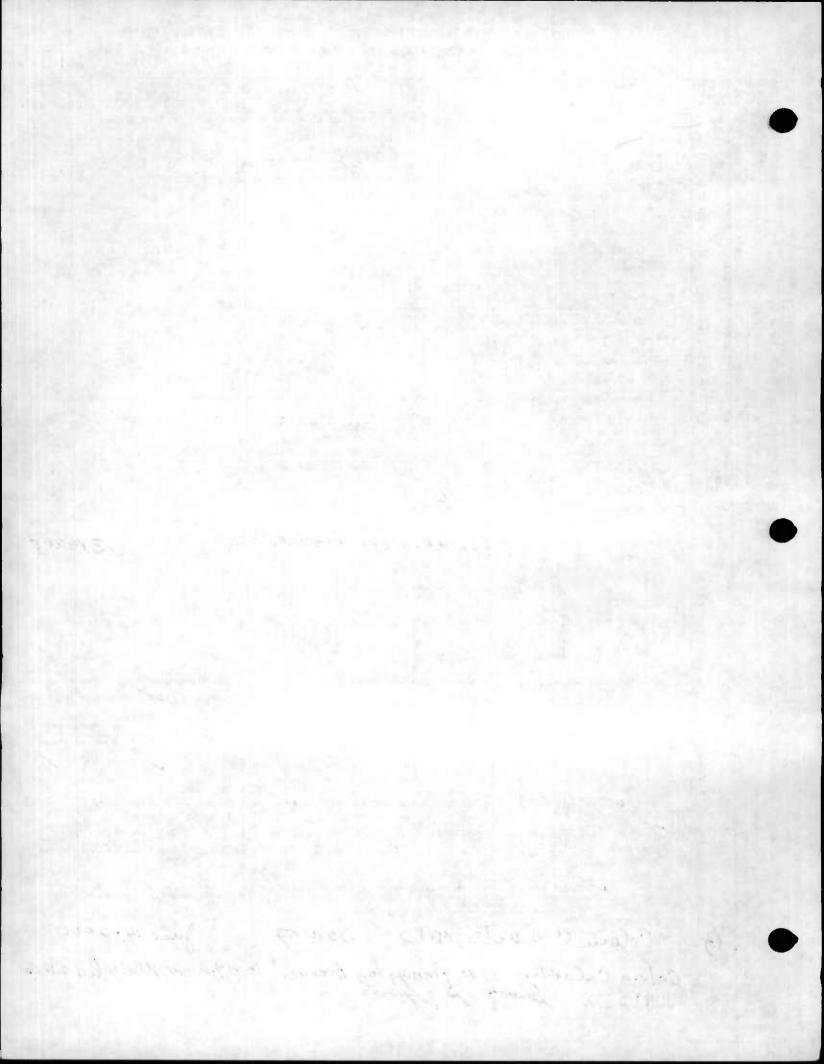


## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Funeral Director	5. Social Security Number 6. Sec		s. last birthday) If U	Inder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt		9. Birthplace (State or Foreign Country)  Md	
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should Men marke umarke	19a. Informant's Name/Relationship (Ty	me Print)	19h Mailing Ad	dress (Street	and Number or Ru			State Zin Code)	
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or Attended the deet deet deet deet deet deet de	2 Accident investigation 3 Sulcide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec			2010	28f. Location (City or Tox		er or Rural Route Number,	
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Withir Comp	29b. Signature and title of certifier	0 -4	_	29c. Licens	se number		29d. Date signed	(Month, Day, Year)	
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X	30. Name and address of person who co	er 47-10 (	enning to	y Au	ence. 1	Bactim	ory Me	4, 2000 ary fand 2120	
State	31. Date filed (Month, Day, Year)	Sen 32 Rogistrar's St	nature sport	2					

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Nama (First Middle Last) 2. Data of Death Month **Physician** June 9 2:00 pm. Louise Catherine Weitzel 2000 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spa Creek Center- Genesis Eldercare Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 8/14/1917 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 XF 215-05-2537 Yrs. 82 Director Baltimore Usual Rasidance of Dacedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 28a-f Md. Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 me 23a or 8121 Armiger Dr. 21122 U.S.A Funeral death 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ② No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Nevar Marriad 2 ☐ Married Saltimore, Maryland 21215-0020 b If Yas, Giva Yaar or Datas: 1 Ves 2000 Specific Specify: White à 31☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) College (1-4or 5+) 6th Cook McDonalds 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Heelth and Mental H tant: If item 27 is marked oth jury or other traumatic even Be John William Deck Louise Teresa Barbernitz 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Nancy Schultz/ Daughter 8121 Armiger Dr. Pasadena Md., 21122 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 ☐ Burial 2X Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 6/13 Towson, Md. 21. Signeture of Funeral Sarvice Licensee 22. Nama and Address of Facility Gonce Funeral Home P.A. namucoulu econe 4001 Ritchie Hwy. Balto. Md. 21225 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart leiture. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immedieta Cause (Final disaasa or condition rasulting in death) /Medical on Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and s the burial-transit BY YTUS The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Duego or as a consequ P.O. Box 68760. that initiated evants rasulting in death) Last Dua to (or as a consequence of) use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25No 3 Probably 4 Unknown signed b þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 No Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, I 25. Was case refarred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Panding 1 Yes 2 No invastigation 2 Accident

Records, Division of Vital

To the Hospital or Atta-within 24 hours after de-To the Funeral Director completely filled in by the Medical State Registrar

6 Could not be datarmined

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of person who complated causa of death (Item 23a) (Type, Print)

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32 Begistrar's Sign

3 Suicida

29a. Cartifier

4 Homicida

(Check only one)

30. Name and addrass

29b. Signature and title of portifiar

JUN 1 5 2000

🙀 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

Annotoly

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

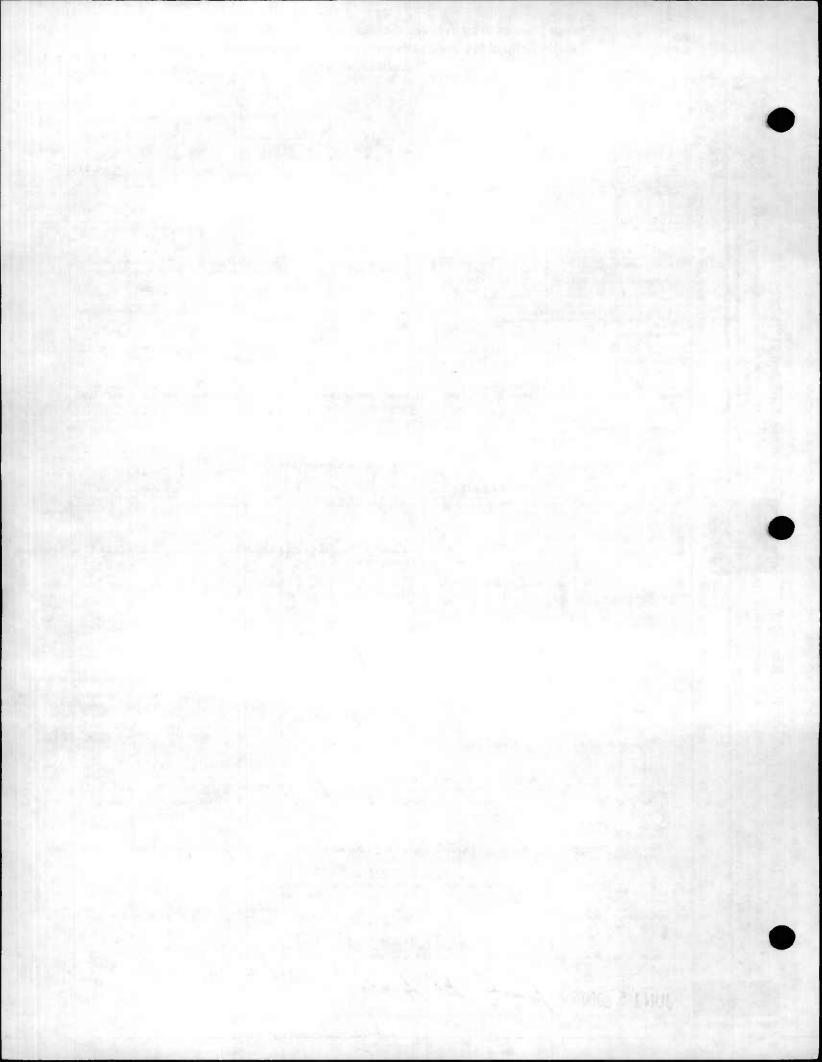
29c. License number

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

1413

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

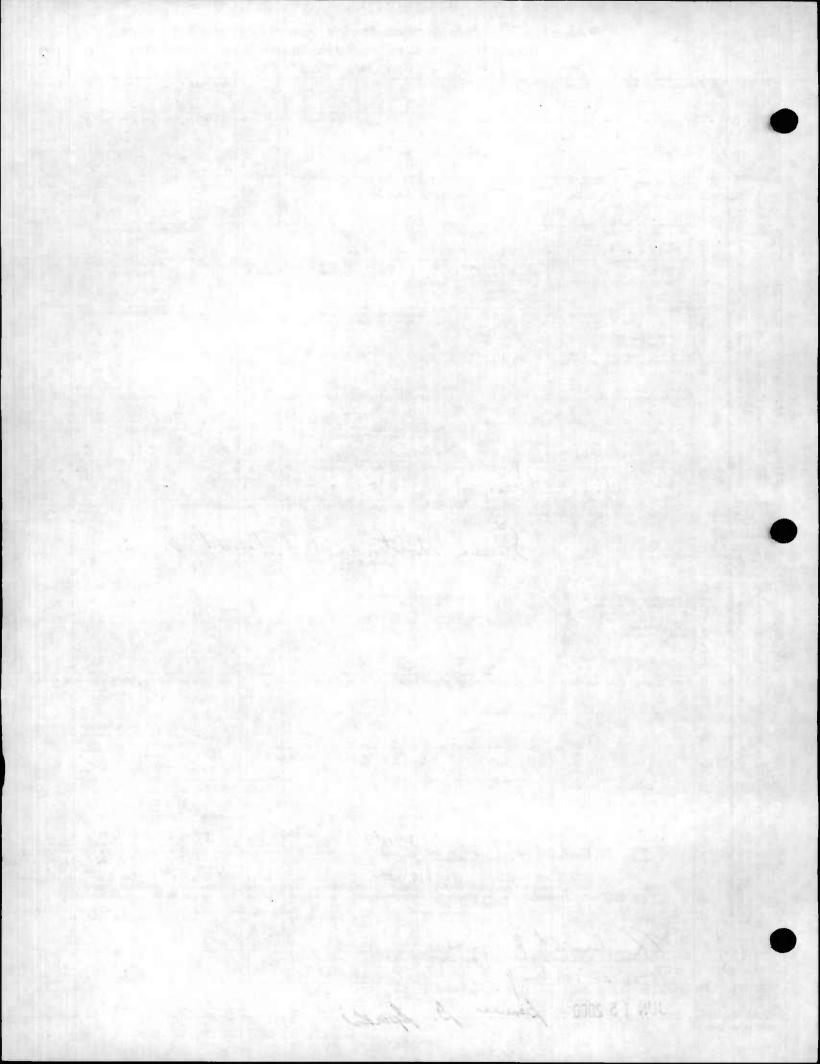


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DHMH 16 Rev 6/95

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month Yeer Physician 676 ARROL notino 2000 JUNZ /Medical 4c. County of Death 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HoHow BALTIMORS TSVO If Under 24 Hrs. If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours M 2DF 80 Yrs. 8370 Director 105 09 1ARY) INA Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits Items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 200 No Director SARYLAM BALLIMOR 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral wallo DVQ-21234 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 ☐ Yes 250 No If Yas, Giva Yaar or Detes: 1 Never Merried 2 Married Maryland 21215-0020 "natural", or 1 Yes 2 No Specify þ 3 Widowed 4 □ Divorced WHITS Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is merked other than any injury or other traumatic event, as Me College (1-4or 5+) HYRS. Elementery/Secondery (0-12) 124RS B+O. KAILROAD 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) BROWN (W)-DRA. A 106Linb 2 YUV 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Hollow Love Merinb Baltimore, 20e. Mathod of Disposition 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, Stete JUNE 14 ■ Buriel 2 Cremetion 3 Ramoval from Stete BALTIMORE 1 ARTLAND 4 ☐ Donetion 5 ☐ Other (Specify) MILER 2000 21. Significa di Euneral Service Licensee 22. Name and Address of Fecility 21234 10B123 8300 HARFORD (20 AD) 1ARYLAND 23a. Pert1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete tntarvat Batween Onsat end Death **Physician** rteriosclentic Cardiovascular /Medical Immediate Cause (Final ear diseasa or condition resulting in death) Examiner Due to (or as e consaquence of): Examiner The law requires that the death certificate be executed the burial-transit Sequentielly list conditions, if eny, taading to immediata cause. Enter Underlying Cause (Disease or Injury that initieted events resulting to death) Last and Due to (or es a consequence of): Box 68760, by Physician/Medical Due to (or as a consequence of): lor use as signed by the a d be detached I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uas contribute to the cause of death? of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to paga 2 should Completed 24a. Was an autopsy performed? Deen completion of cause of deeth? After this certificate has 20 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Physician: funeral director, 25. Wes case referred to medicat exeminar? Medical Certification: To Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yas \$ No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of tnjury 28d. Describe how injury occurred 28c. Injury at Work? Division or Attending Neturet 5 Pending investigation ours after death. eral Director: Af lilled in by the fu 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 ☐ Homicida To the Hospital o within 24 hours af To the Funeral Di completely lilled I Carlifying Physician: To the best of my knowledge, daeth occurred et tha tima, data and place, and dua to the causa(s) and manner as stated. Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta end place, and due to the cause(s) and menner steled. 29a, Certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Dey, Year)

JUN 1 5 2000

Marc

I. Leavey

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

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DHMH 16 Rsv 6/95

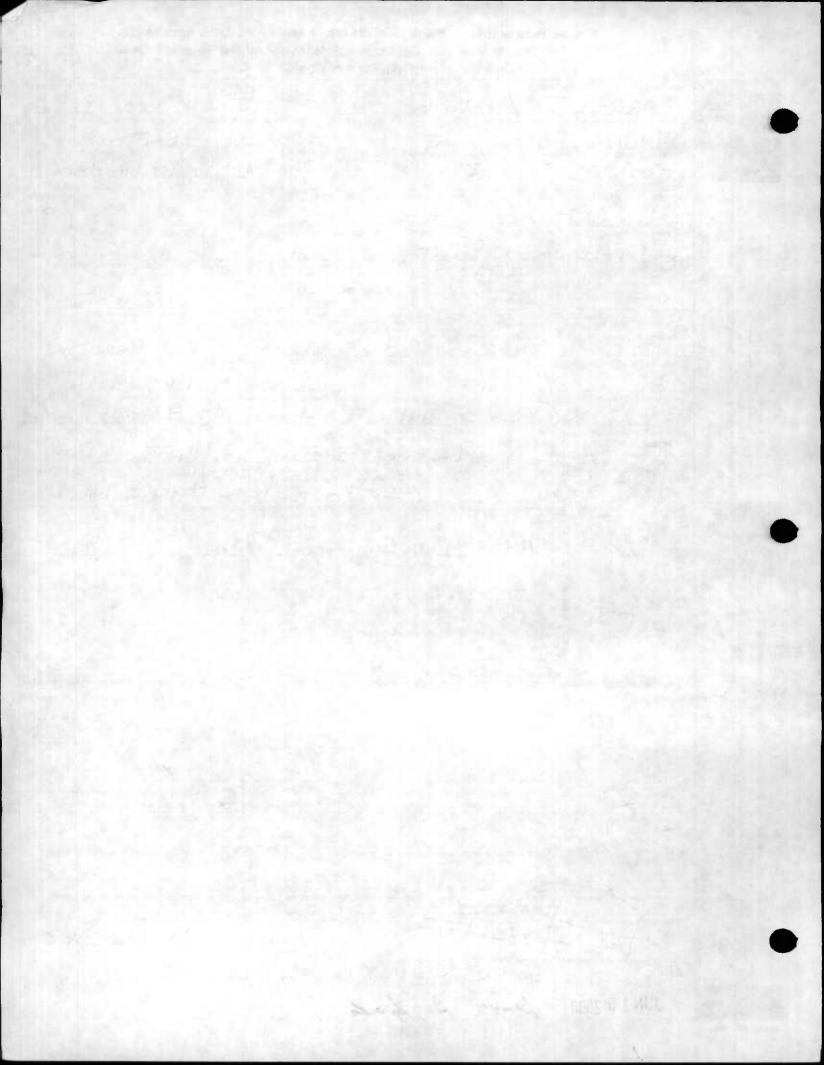
1205 York Road

32. Registrer's Signetyre

17041

Ste 38 Lutherville MD

UNE 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\begin{align\*}
\emptyset{\text{Proposition}}
\text{On the partment of Health and Mental Hygiene}
\emptyset{\text{On the part Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JUNE Physician 2000 6, 6:25 PM CHLOE ROSE ACREE /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□ M XX F NONE Yrs. Director 14 May 23,2000 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Od. fnside City Limits 23s or 28s-f show other traumatic event, the Medical Examiner must be nothlised at Yes 2 No Maryland Baltimore City Baltimore City Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 5914 Marluth Avenue 21206 USA Funeral death Herne Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after name of Health and Mental Hygiene.
Int: If Item 27 is merked other than "natural", or fis 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None 0 N/A None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kelley Lynn Burgess Sherman Thomas Acree, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5914 Marluth Avenue Baltimore, Md. 21206 Kelly L. Acree 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If Ne any Injury or of 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6-10-00 Baltimore, Md. 22. Name and Address of Facility
Lassahn Funeral Home 21. Signature of Funeral Service Licenses 7401 Belair Rd. Baltimore, Park Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** 13 DAYS EXTREME PREMATURITY /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of). Examiner RESPIRATORY DISTRESS SYNDROME 13 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Bud Physician/Medical the Due to (or es a consequence of): for use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown RENAL FAILURE þ 8 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed INTRAVENTRICULAR HEMORRHAGE page 2 certificate has 1□ Yes 2 No 1 ☐ Yes 2 No 25. Was case reterred to medical examiner? edical Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? After t 28d. Describe how injury occurred 5 Pending Investigation s after death. 1 Yes 2 No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

The law requires that the death certificate be executed Box 68760. Records, P.O. of Vital or Attending Physician: Division To the Hospital o within 24 hours af To the Funeral Di

Saltimore, Maryland 21215-0020

one) 29b. Signature and title of certifier

29c. License number D41343

29d. Date signed (Month, Day, Year)

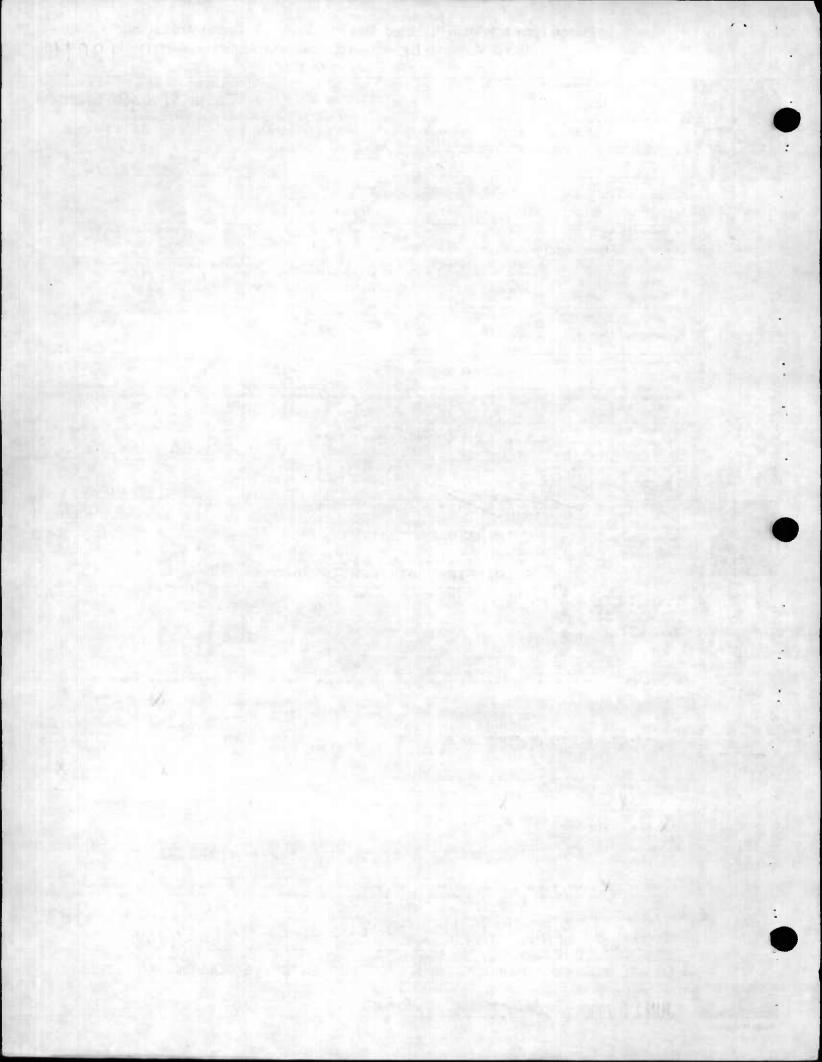
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL EDWARD LANGBAUM, M.D. 7601 OSLER DRIVE TOWSON, MD 21204

State Registrar 31. Date filed (Month, Day, Year) JUN 15 2000

32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician Thomas Henry Bolton 26, 200-4c. County of Death 2000 1A) 1300 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Union Hospital Elkton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1⊠M 2□ F 38 Yrs 220-14-1455 Director Delaware 11-24-1911 **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or flams 23a or 28a-f show 1 ☐ Yes 2 No Director Delaware New Castle Townsend 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filled within 72 hours eiter deeth with till Department of Health and Mentel Hyglene. Important: if item 27 is marked other than "natural", or Nems 23a or 2 eny injury or other traumetic event, the Medical Examinator mass than 1900s. 20 Cart Rd. 19734 IISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baitimore, Maryland 21215-0020 1 Yes 2K No Specify: 3 D Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heating/AC Mechanic Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B 2 Howard Bolton Clare Biddle 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Money Rd., Townsend, DE. 19734 Jeanette Bailey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 Cremetion 3 Removal from State Gracelawn memorial Pk.5-31+00 Wilmington.DE. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
DANIELS & HUTCHISON FUNERAL HOME 21. Signature of Funeral Service Lig 212 N. Broad Street, Middletown, DE. 19709 TON 1121 fram 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician fmmediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be assecuted Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown P Records, 24b. Were autopsy findings available prior fo Completed 24a. Was en eutopsy completion of cause of death? s cartificete has b 1 ☐ Yes 2 ☐ No. 1 Yes 2 No Division of Vital To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funeral Director: After this cartiflor completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2X No 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

State Registrar (Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

MAY 3 1 2000

281 E. Main Street, Rising Sun, Md Thomas A. Biondo, MD. 32. Registrar's Signature

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s)

29c. Licer

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** June Edel Caroline Bach 2000 11:10 am /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Laurelwood Nursing & Rehab. Cecil Elkton 8. Data of Birth (Month, Day, Year) Sept. 27 1909 If Under 1 Yaer If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days 1□M 2X F Vie 90 Director 213-46-3401 Norway Usuef Rasidence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 No Director Maryland Cecil Chesapeake City r than "natural", or items 23s or 28s-f 10e. Street and Number 10f. Zio Coda 10g. Citizen of What Country? 100 Grayson Ave. 21915 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, Whita, atc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 🕱 No Specify: Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elamentary/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if Item 27 is marked othe any injury or other traumadic event, poids. 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) Be Christian Dreyer Meeg Karoline Andersen 2 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 49 Chesapeake City, MD 21915 Howard A. Bach/Son 20b. Place of Disposition (Nama of cematary, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removel from Steta Bethel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6-9-00 Chesapeake City, MD 22. Nama and Addrass of Facility R. T. Foard Funeral Home, P. A. 21. Signature of Fuctoral Service Licenses unan 318 George St., Chesapeake City, MD 21915 orgal 23a. Part I Entar the disease, or complications shock or heart tailure. List only one could caused the/daeth. Do not entar tha moda of dying, such as cardiac or raspiratory errast, on each line. Approximeta Intervel Between Onsat and Daath Physician Immediata Causa (Final disaase or condition rasulting In death) /Medical Examiner Dua to (or es a consequence of): Examine 8 47 Sequentially list conditions, if any, faeding to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? P.O. igned by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown Records, ð 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? complation of cause of daath? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital certifica 8 25. Was case ratarred to medical 26. Place of Death (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yas 2 No Certification: To 6 28c. fnjury at Work? 27. Manney of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Affar Attanding 1 Natural 5 Pending invastigation death. 1 Yas 2 No 2 Accident Director: 6 Could not be detarmined 28f. Location (Straet end Number or Rurel Routa Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) after 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral Di completely filled in Medical 1 Certifying Physician: To tha best of my knowledga, daath occurred at the time, data and place, and dua to tha causa(s) and mannar as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

Registrar

**DHMH 16 Rev 6/95** 

29b. Signature and titla of certifier

31. Data filed (Month, Day, Year)
JUN 0 2 2000

and address of person who completed,

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ausa of death (Item 23a) (Type, Print)

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32. Registrar's Signatura

29c. License number

2230

29d. Date signed (Month, Dey, Year) 2000

JUNE DE POSTE DE L'ANDRE DE L'AND

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 19017 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 2000 Harry Blendy June 5:40 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 752 Biddle Street Chesapeake City If Under 1 Yaer | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Yea Sept. 29, 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Months 1 Ø M 2 □ F Yrs. 222-10-7318 Director Maryland Usual Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 1 No Directo Maryland Cecil Chesapeake City 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 752 Biddle Street 21915 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 (X/Yes 2 □ No If Yas, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Maritei Stetus Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Iron Worker Construction 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Nema (First, Middle, Last) å Stephen Blendy Tekla Cebrick 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Grace L. Blendy/Wife 752 Biddle St., Chesapeake City, MD 21915 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete St. Rose of Lima Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 6-5-00 Chesapeake City. MD 21. Signatura of Juneral Sarvice Licenses 22. Name and Address of Facility R. T. Foard Funeral Home, P. A. 000 318 George St., Chesapeake City, MD 21915 23a. Parti. Enter the disease, or complications of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. Approximate Intervel Between Onsat and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) oncestive HEART FAILURE Examiner Due to (or es e consequence of): Examiner ARTERY DISEASE CORDARRY Due to (or es a consequence of): Sequentially list conditions, Physician/Medical by Completed Be

attending physician and for use as the burial-transit certificate be executed Division of Vital Records, P.O. Box 68760, signed by the certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to Certification: To

death with the Maryland

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permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentel hygiene. Important: If Hean 27 is marked other then "natural", or itema 23s or 28s-f show any injury or other treumatic event, the seadess Examiner must be notified at

Baitimore, Maryland 21215-0020

If any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initieted evants resulting in death) Last	cDue to (	or as a consequence of)	к							
Part II. Other significant conditions of	contributing to death but not re-	sulting in the underlying	cause given in Part t.	23b. Did tobacco uee co	entribute to the cause of death?					
METASTATIC	BLANDER AN	b MOSTA	TE CANGES	1 Yes 2□ No	3 Probably 4 Unknown					
ASBESTOS-15	10 3 3 1/2			24a. Wes an autopsy performed?	24b. Were autopsy findings evailable prior to completion of cause					
HYPERTENSTON	OLETES			1 ☐ Yes 2 No	of death?					
25. Was casa rafarred to medical	26. Place of Death (Check only one)									
examiner?	Hospitel: 1 Inpatient 2	☐ ER/Outpatient 3☐ D	Other: 4 Nursing	Home 5 Residence 6 □Ott	ner (Specify)					
27. Mannar of Death  1 ⊠Natural 5 ☐ Pending  2 ☐ Accident invastigatio		(Month, Day Year) Injury Work?								
3 Suicide 6 Could not be datarmined		noma, ferm, street, fecto	28f. Location (Street and Numi City or Town, Stata)	ber or Rural Route Number,						
29a. Certifier (Check only one) 154 Certifying Pt 2 Medicat Example 154 Certifying Pt 2 Medicat Exampl	ysician: To the best of my knowniner: On the basis of axamine end manner stated.	owledge, death occurred ation end/or investigation	d at the tima, data and plac n, in my opinion, death occ	e, and dua to tha causa(s) and murred et the time, dete and plece,	anner as stated. and due to tha cause(s)					
29b. Signature and title of confiller		29	C. License number	29d. Data signe	ed (Month, Day, Year)					

130291

6/2/00

State Registrar

Medical

31. Date filed (Month, Day, Year) JUN-0 2 2000

30. Name and address of person

32. Registrar's Signatura

d cause of death (Item 23a) (Type, Print)

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## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

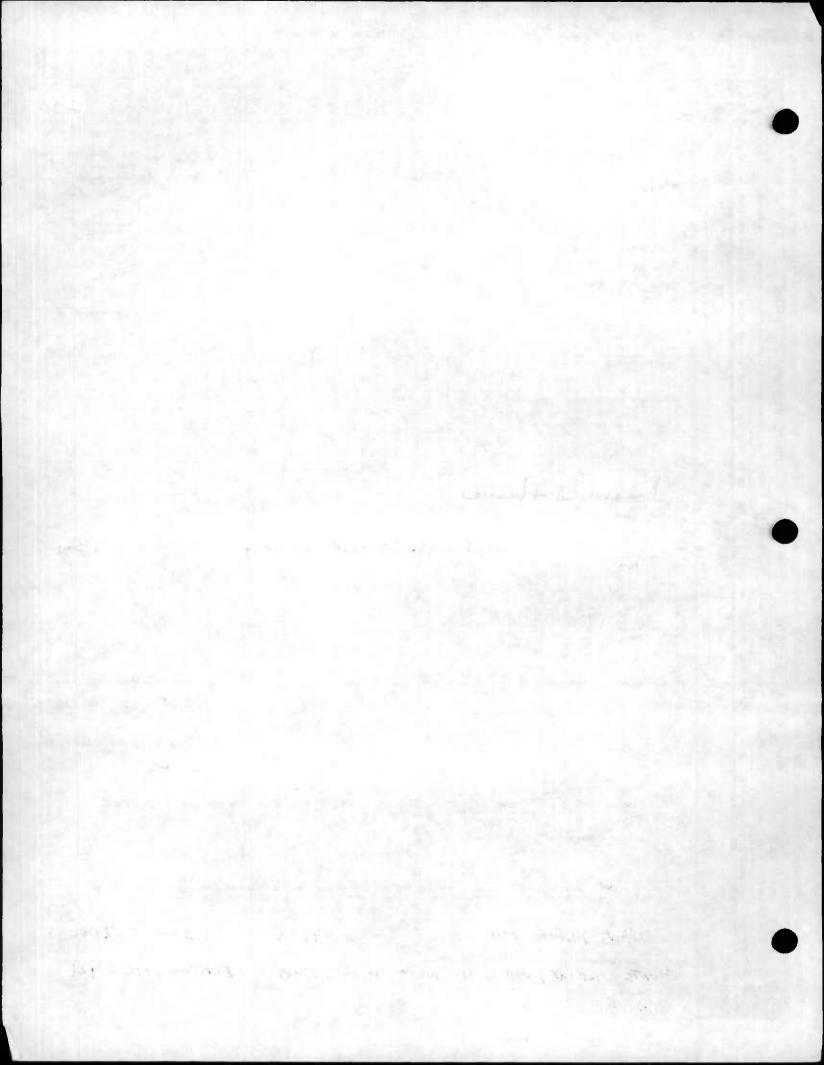
State of Maryland / Department of Health and Mental Hygiene 19018 Certificate of Death Reg. No 1. Decedent'a Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth Day Month Vear **Physician** 2000 Margaret Kirk Boyd 230 June /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Cecil Union Hospital Elkton 8. Date of Birth (Month, Day, Year) 6, 1911 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🗙 F Months Philadelphia Yrs 216-07-1833 88 Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits therms 23s or 28s-f show with the Maryla 1 ☐ Yes 2 XNo Directo Maryland Cecil Elkton the Medical Examiner must be notifi 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21921 United States 163 Kennedy Boulevard Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filled within 72 hours after nent of Health and Montal Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married ъ 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Owner/Operator Motel 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 86 is marked Florence Cooke N. Kirk 2 Wilmer 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important! If Item 27 is any injury or other trace 307 Park Circle , Elkton, Marvland 21921 Camillus C. Kirk/Brother 20b. Place of Disposition (Neme of 20c. Location - City or Town, Stete 20a. Method of Disposition Dete cemetery, cremetory or other place) 1 ☐ Buriel 2 X Cremation 3 ☐ Removel from State 6/2/00 West Chester, PA 4 ☐ Donetion 5 ☐ Other (Specify) R.A. Ferris Inc. & Co. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. icke 21921 103 W. Stockton Street, Elkton, MD. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Acute Gastrointestinal disease or condition resulting in deeth) Da Examiner Due to (or as a consequence of) Examiner The law requires that the death certificata be executed burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco was contribute to the cause of death? Division of Vital Records, P.O. 1 Yas 2 PNo 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1□ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 1 [ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this funeral 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how Injury occurred Aftar t s after des... al Director: After 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital within 24 hours a To the Funeral C completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) June 1,2000 Morte Makous, MD D-44783 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) ELKTON, MO 21921 MONTE MCKOUS 111 Street MO West 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rsv 6/95

Registrar

JUN 0 2 2000

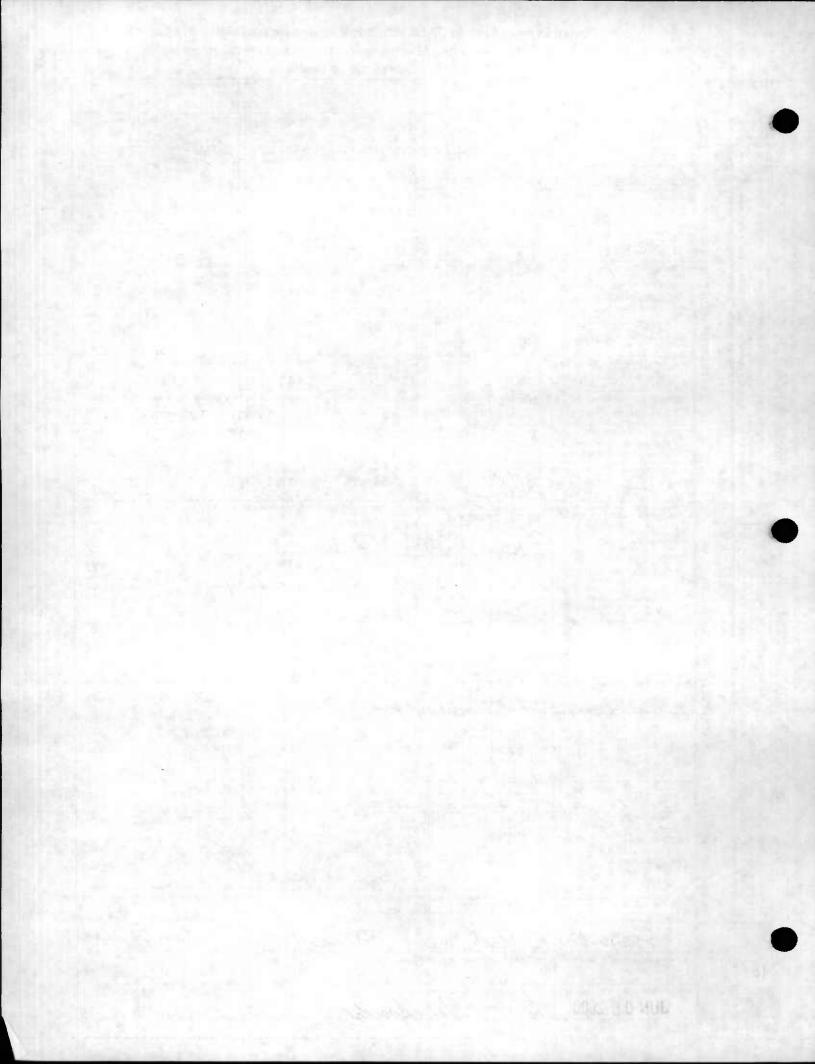


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State of Maryland / Department of Health and Mental Hygiene 00 10010

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or	219-30 Usual Residence		1□ M 2 <b>X</b> F	67	Yrs. Mont	ths Days	Hours	Min.	8. Date of Birth (Month, Day OCT 2]	1932	Mar	yland	
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to	DE	New C	astle	Midd	lletown	1						1 ☐ Yes 2 💆	
Director	10e. Street and i	Number			10f.	Zip Code			1	0g. Citizen of 1	What Coun	itry?	
	1133	Marl Pit	t Rd.			19709					U.S.A.		
Funeral	11. Marital Statu	s	12. Was Deced	dent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specify Yas or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					No- 14. Race - American Indian, Black, White, etc.			
by	56005	arried 2X Merried d 4 □ Divorced		2 No		es 200 No				y: White			
de de	15. Decedent's Education 16a. Decedent's Usuel Occupation (Specify only highest grade completed) (Give kind of work done during most of v							of workin	10	16b. Kind of Bi	usiness/Ind	dustry	
Completed		econdary (0-12)	College (1-	4or 5+)	tife. DO NO	(Give kind of work done during most of working tife. DO NOT use retired)							
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Be (		ne (First, Middle, Las							(First, Middle,		n <i>e)</i>		
2	Will:	iam D. G	reen				Li1	lian	Mae 1	Hall			
		Name/Relationship			9b. Mailing Add								
		nd Burri	s (hu	sband)			Pit	Rd.					
	20e. Method of D	Disposition	□Removal from S	como	of Disposition ( etery, crematory	(Name of or other pla	ce)	I	Date	20c. Location -	City or To	wn, State	
		n 5 Other (Spec		01d	Drawy	ers (	Cem.	1 6	5/6/00	Odes	ssa,	DE.	
	21. Signifium of	Funeral Service Lio	00500	2			ss of Facility						
	1 -	AL DO	XVIS	M005								Schaec	
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	enog of h	near rapure. List oni	ly one ceuse on ea	ich line.								Interval Between Onset and Deat	
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	disease or condition resulting In death)  Due to (or as e consequence of):										i	42.	
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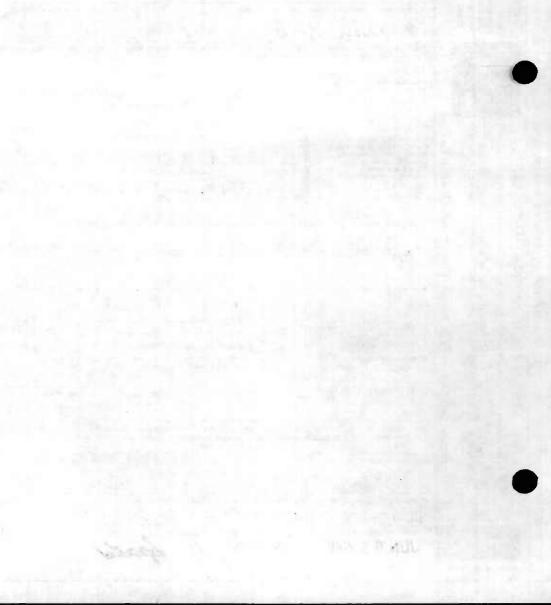
DHMH 16 Rev 6/95



# Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

L.I.					C	ertificat	te of	Death			Reg. No.	10 1	9020
hysician	1. Decedent's Name (First, M	100								2. Date of De Month	eath Day	Yaar	3. Time of Death
lical	Mildred Har					_	-	45 Ch. To		Juve	2	2000	954 AM
er	4a Facility Nama (# not instit Fallston Ge	neral	l Hospi	tal				Fal.	1sto		На	inty of Death irford	
	5. Social Security Number 419-32-8405		ex □M 2ŽŠF	7. Age (h	n yrs. last birthdi Yrs	Months	Days		Min.	8. Date of Bid (Month, Di Sept 10	1926	9. Birthp Cour Alaba	
	Usual Residence of Deceden 10s. State 10b. Cor			10	c. City. Town or	Location	-					11	IOd. Insida City Limits
Director		arfo	rd				berd	een					1) Yas 2 □ No
	10e. Street and Number 504 Oak Str	eet				10f. Zip Code 21001					10g. Citizen of What Country? USA		
by Funeral	11. Marital Status  1 Never Married 2 1  3 Widowed 4 1 Divor		12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	orces? 2⊠No ve	r in U,S. 1	3. Was Dece If Yes, spe	cify Cub	en, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)		Race - Amaric Black, Whita, poily: B1a	alc.
Completed	15. Dece (Specify only his Elementary/Secondary (0-1	1	de completed) College (		16a. De (G	cedent's Usu ive kind of wo b. DO NOT u	ork done ise retire	during mos	st of work	ing		f Business/In	
Š	17. Father's Name (First, Middle, Last)		5+			Teacher						Public School	
To Be	Robert L. G					18. Mother's Nama (First, Midd Jimmie L. Co						name)	3-31
qury or other traums	19a. Informant's Name/Relati		Daug		_				een, MI	-		Code)	
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremeti			State	cemetery, c	Place of Disposition (Name of Data Deta Deta Deta Deta Deta Deta Deta					20c. Location - City or Town, Stata		
	4 Donation 5 Other (Specify)  The Green Mount Cemetery 6/3/00 Baltim  21. Signature of Funeral Service Licensee  Lisa M. Scott Fun  552 Lewis Street, Havre de Grace											uneral	Services
	23a. Part1. Enter the disease shock, or heart failure.	, or comp List only o	olications that cone cause on e	caused the each line.	death. Do not								Approximala Interval Between Onsal and Daath
	Immediate Cause (Final disease or condition resulting in death)		. ML	UT	PCS	- Y	ny	IEL	01	NA			SYEARS
Examiner			b. H	YP	ERL	115C	00	SITY					8 DAYS
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Į	c. S	EP	so (or as a cons			3					8 DAYS
/Medical	resulting in death) Last	l	d. 01	Due	to (or as a cons	equence of):	Po	AT	HY	P	H		8 DAYS
Physician	Part II, Other significant cond											contribute to	o the cause of death?
by	ACUTIZ A	CER	) pr 1-	ATL	OK12	,001	74	OLO!	14/1	77	an autopsy	24b. W	are autopsy findings
Completed										perfe	ormed?	00	allabla prior to impletion of cause death?
										10	Yas 2 N	0 1[	□Yas 30No
8	25. Was case referred to med examiner?	119.00	Hospital: )/				10	26. Place	e of Deat	h (Check only	one)		
on: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Per		28a. Date	Inpatient of Injury th, Day Ye	2 ER/Outper 28b. Time ar)		28c. Inju Wo	ry at		me 5 Res 28d. Describe			(y)
Certification:	2 Accident inw 3 Suicide 6 Co	estigation uld not be ermined		of Injury -	At home, farm, pecify)	street, factor	1271	Yes 2			Street and Ni wn, State)	umber or Rure	al Routa Number,
Medical Certifi	29a. Certifier ) Certifier (Check only ane)	fying Phy cal Exami	iner: On the bi	best of my	y knowledge, de mination and/or	ath occurred investigation	at the ti	me, date an opinion, dea	nd place, ath occurr	and due to the ed at the tima,	cause(s) and data and pla	I mannar as s ce, and dua le	tated. o tha causa(s)
Me	29b. Signature and title of cer	tifier	ar na i i i i da i	stated.		29	c. Licens	se number			29d. Date si	gned (Month,	Day, Year)
	* Cologra	Mu	5	MIS	) ************************************		D:						d,2000
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Steven Thomas Brandenburg June 12:15 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 24 Hrs. 8. Date of Birth Hours Min. Modelh Day, If Under 1 Year 7. Age (In yrs. last birthday) 56 Yrs. 5. Social Security Number 6. Sex 1以 M 2□ F Birthplace (State or Foreign Country) **Funeral** Days Maryland 215-44-9240 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Meryland Department of Heelth and Mental Hygiens. Important: If them 27 is marked other than "natural", or thems 23s or 28s-f show any Injury or other treumatic event, the Heddie Earning. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Frederick 1 ☐ Yes 2 No Director Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14515 Old Catoctin Rd. 21783 U.S.A. Funaral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) t4. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 3altlmore, Maryland 21215-0020 1 Yes 2 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Truck Co. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) e Ray S. Brandenburg Margaret M. Swope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis J. Brandenburg (Wife) 14515 Old Catoctin Rd. Smithsburg, Md. 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Buriel 2 □ Cremation 3 □ Remg June 5. Pleasant Valley Cemetery 4 Donation 5 Dother (Specify) 2000 Smithsburg, Md. 21. Signature of Funeral Se 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg. Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner physicien end the buriel-transit or Attending Physicien: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Due to (or as a consequence of): ete hes been signed by the e page 2 should be deteched i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably Wunknown à 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy parlormed? completion of cause of death? certificate 2 N 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Ves 20 No 1 (Inpatient Certification: To 2 ER/Outpatient 3 DOA 핥 27, Manper of Di 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural n 24 hours efter death. he Funeral Director: Afte pletely filled in by the fun t ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital Medical The cartifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and menner es stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie completely iner: On the basis of exa-and manner stated. (Check only one) To the ş 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

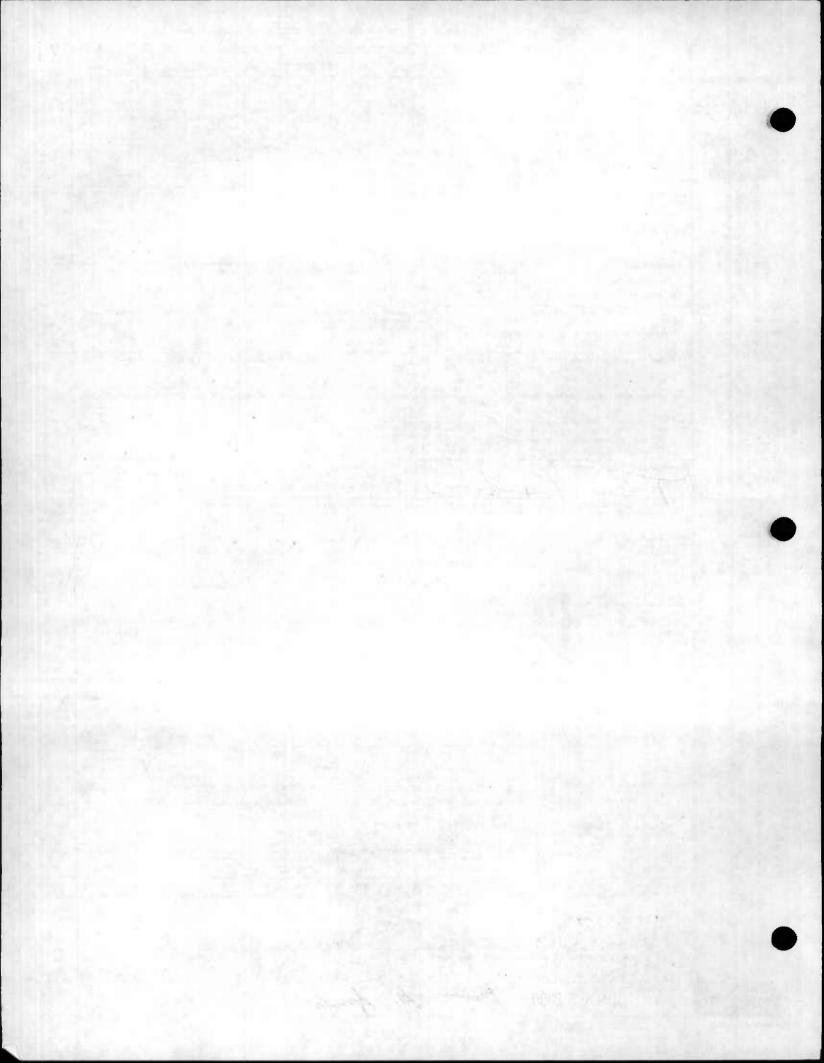
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who completed cause of death (flem 23a) (Type, Print)

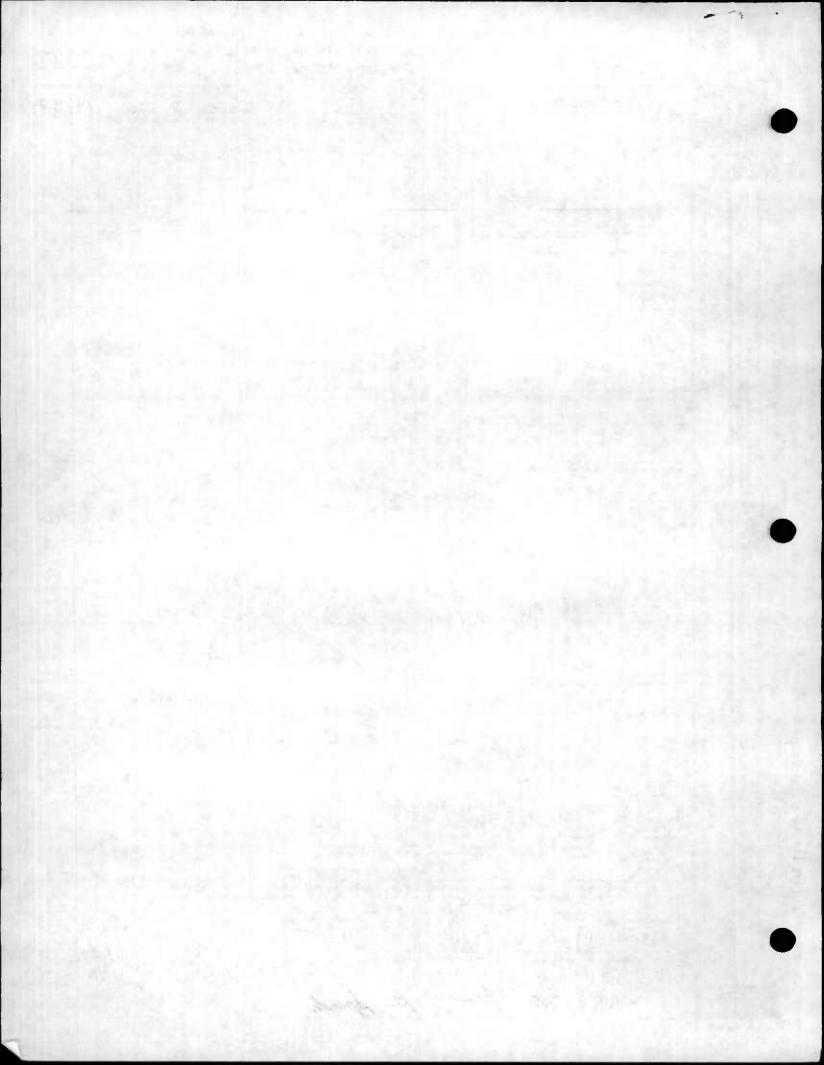
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Physician	E A SAN DES	me (First, Midd Villiam		h BROO	)KS	72	tificate o		ou.,,	2. Data of De Month	Day	Yaar	3. Time of Deat
/Medical	4a Facility Name							4b.	. City, Town, or Lo	cation of Deatl		2000 y of Death	
Examiner	Washing	,			•				Hagersto	าพท			
Funeral	5. Social Security		6. Sex	-		last birthdey)	If Under 1 Ye		If Under 24 Hrs.	8. Date of Birth 9. Birthplace (Stat			place (State or Fore
Director	212-01- Usual Residence		1⊠ M	2□ F	8	Yrs.	Months Day	ys	Hours Min.	May 30	, <sup>ve</sup> 1919	Mary	yland
filed within 72 hours after death with the Meryland Hygiene.  Thysiene.  The than "natural", or items 23a or 28=1 show ent, the Mesical Examinat rotat be notified at the Completed by Funeral Director.	10a. State Maryland	10b. County Balti		ngton		y, Town or Lo ltimor		iam	sport		13.4		10d. Inside City Lin → <del>NEIN</del> es 2 ⊠
ifer death with the Mer frems 23e or 28=fs inner must be notified Funeral Director	10e. Street and N 4415 G1			ginia A	venue	Apt.#30	3 10f. Zip Cod		21795		10g. Citizen of U.S.		intry?
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ir, or he by Fur		rried 2 Mar	rried	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	₹No		f Yes, specify C 1 ☐ Yes 2 ☑ N			Specify Yes or No- to Rican, etc.)  14. Raca Black Specify:			hite
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traumatic To	19a. tnformant's l					19b. Maitir	ng Address (Str	eet en	nd Number or Run			, State. Zii	p Code)
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Funerel Director: After this certificate has been signed by the attending physicial tely filled in by the funeral director, page 2 should be deteched for use as the bur tely filled in by the funeral director, page 2 should be deteched for use as the bur lical Certification: To Be Completed by Physician/Medical	Part It. Other aign  25. Was case referexaminer?  1 Yes 2  27. Manner of Det 12 Accident 3 Sequentially list of any leading to couse. Enter Unc Cause (Disease of that initiated ever resulting in death  25. Was case referexaminer?  1 Yes 2	erred to medice No ath 5 Pendii investi Could detern	Hosping 2 ing igetion not be nined 2	oital: 1 ☐ Inpa 88a. Dete of in (Month, £ 88e. Place of t building,	atient 200 plury Pear)  Injury - At hoetc. (Specify st of my known of examinations)	er as a consequence of the conse	nderlying cause  at 3 DOA 28c. If M 1 aet, factory, offi	Othernjury ( Nork?	26. Place of Deat  4  Nursing Ho at es 2  No	24a. Was performed to the Check only of the Check only of the Section (City or To and due to the	Yes 22 No an autopsy primed?  Yes 22 No one) dence 6 Or how injury occu  Street end Num wn, Stete)  ceuse(s) end m	24b. Ward of the Control of the Cont	Vere autopsy findin vallable prior to ompletion of causa f death?  Yes 2 No  Ify)  rel Route Number,
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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dey Month Year **Physician** PATSY L. BREIGHNER May 21, 2000 11:25PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Salisbury Center; Genesis Eldercare Salisbury, Md. Wicomico 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2X F Yrs. 219-56-8619 48 Director USA/Maryland Dec. 6, 1951 Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita ns 23a or 28a-f show 1X Yes 2 □ No Director Crisfield Maryland Somerset 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code death with 21817 102 Cove St. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yea, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🛣 No 14 Reca - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married PATSY LEE BREIGHNER Baltimore, Maryland 21215-0020 8 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) At Home Homemaker Grade 7 marked other 17. Fsther'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be finent of Health and Mental int: If item 27 is marked of Frank Ward. Jr. Emma Geraldine Adams 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Louise Rubio (sister) 26644 Old State Road - Crisfield, MD Department of Heat Important: If item 2 any Injury or other pince. 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 M Burial 2 ☐ Cremetion 3 ☐ Removat from State Crisfield Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 5/25/00 Crisfield, MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw 306 W. Main St. - Crisfield, MD 21817 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediete Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner for usa as the burial-tranait The law requires that tha death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Box 68760. Due to (or es e consequence of) P.0. Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy tindings available prior to completion of cause of deeth? director, page 2 should Be Completed 24a. Wes an eutopsy performed? this certificate has been 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: after death.

Director: After this certifica 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No P 1 | Inpatient 2 | ER/Outpatient 3 | DOA To the Hospital or Attending Physi within 24 hours after death.
To the Funeral Director: After this c completely filled in by the funeral dir 27. Menner of Death 28e. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and title of bertifie 29c. License number 29d. Date signed (Month, Dey, Year) (50) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1104 HEALTHWAY DR., SALISBURY, MD 21804 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9024 AMENDED ITEM #23a PER MD G784 6/14/2000 AH Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** March 30, Judith W. Blanche 2000 7:40 pm /Medical 4a Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15115 Interlachen Drive Apt 1007 Silver Spring Montgomery If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days Hours Min. Yrs. Director Aug 9, 1914 53-05-5167 New Jersey Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 28s-1: Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8 'natural', or items 23s. 15115 Interlachen Drive Apt 1007 20906 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, apecify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If them 27 is marked other any Injury or other traumatic events. 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) ag Jacob Waypa Martona Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4145 Great Oak Road, Rockville, MD 20853 Patricia B. Tyrrell / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Descrial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 14/3/00 Silver Spring, MD 22. Nama and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee ames 500 University Blvd., W, Silver Spring, MD 20901 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, wheelt failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** fmmediate Cause (Final disease or condition resulting in death) /Medical PNEUMONIA Aspiration 30 days Examiner Due to (or as a consequence of) Examiner 30 days b. Pneumonia The lew requires that the death certificate be executed physician and st the buriel-trensi Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disease or injury Due to (or as a consequence ot): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): attending p for use es P.O. Part II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? deteched signed by t 1 Yea 2 No 3 Probably 4 Unknown Records, by been sig 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 1 ☐ Yes 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: director, Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Nesidenca 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Dey Year) After thi 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 5 Panding To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar

15

edical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

A. Khan, MD

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2000 APR 03

30. Name and address of parson who completed cause of death (Item 23e) (Type, Print)

10794 Hickory Ridge Road, Columbia, MD

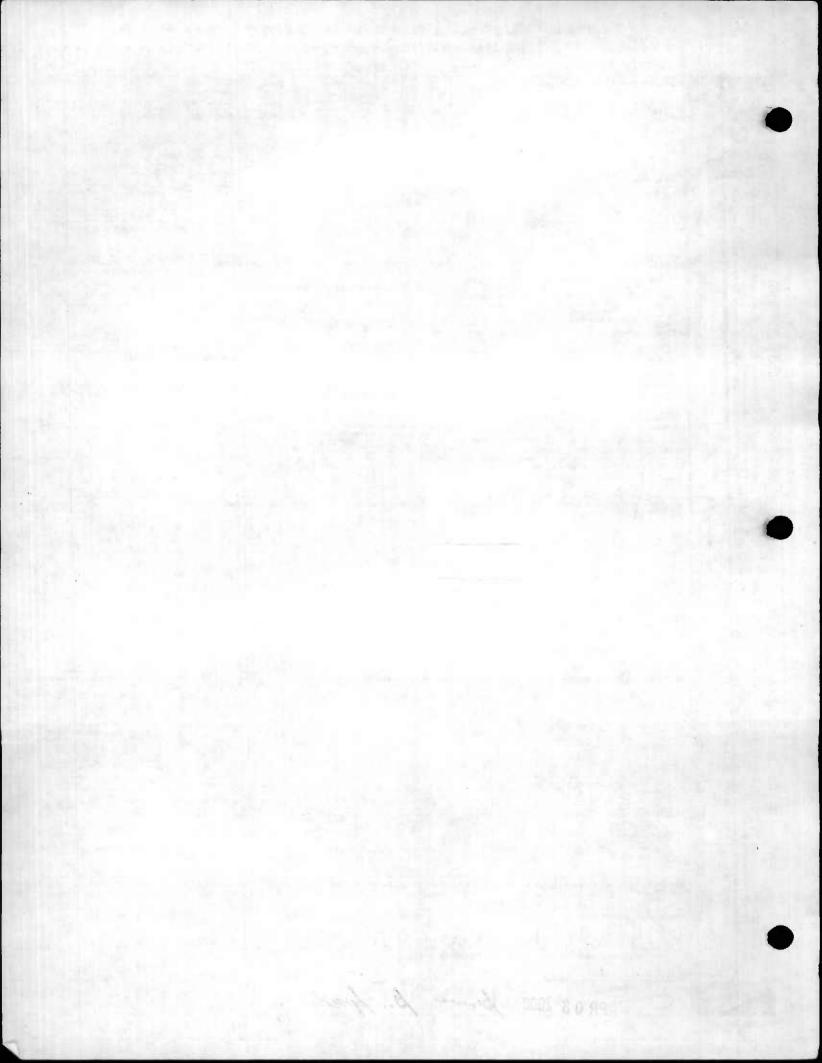
1 Contifying Phyalcfan: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number

D 43323

29d. Data signed (Month, Day, Year)

March 31, 2000

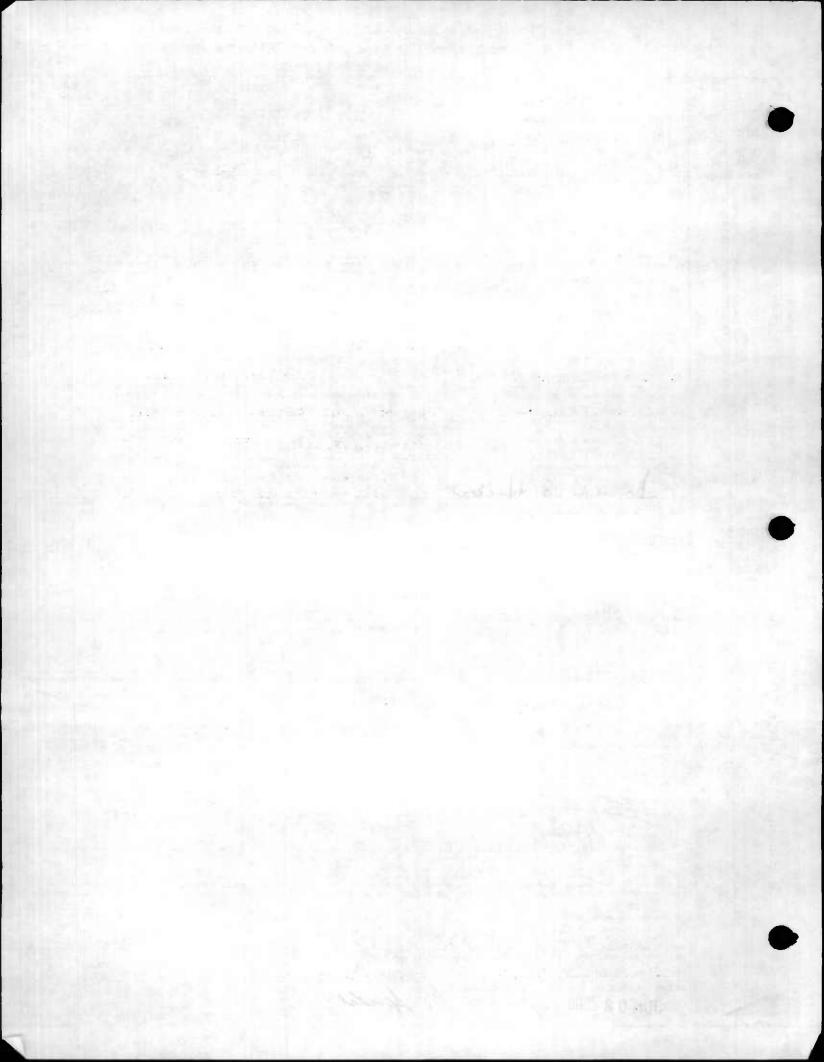


#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** Charles Nathaniel Cox June 2000 0330 A 1 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 151 Kirk Road Elkton Cecil 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 10XM 20 F Yes Director 214-22-3112 July 10, 1922 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Ceci1 Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumstic event, the Medical Examinat must be r Funeral 151 Kirk Road 21921 United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, Whita, etc. 11. Meritel Stetus filed within 72 hours after 1 Never Merried 2 X Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: If Yes, Give Year or Dates Specify: Black ₹ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4nr 5+) Track Man Railroad parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumstic event, obce. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Charles Cecil Brown Josephine Richardson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mabel Shorter/Daughter B5 West Knoll, Newark, Delaware 19711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removef from State June 6, Cedar Hill, Griffith A.U.M.P. Church 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Cemetery Maryland 21. Signature of Funeral Service License 22, Name and Address of Fecility Hicks Home for Funerals, P.A. ers) 103 W. Stockton St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** fmmediete Cause (Finel disease or condition resulting in death) /Medical adevocuranema Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit certificate be axecuted Sequentially fist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that in leading to the conditions of the conditi Due to (or as a consequence of): P.O. Box 68760. Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of) d for use as I Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part f. been signed by the should be detached 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Hiknown Caramenra Records, Š 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Presidence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28a. Date of frijury (Month, Day Year) 27. Menner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Atratural 5 Pending investigation death. 1 TYes 2 □ No 2 Accident after death Director: / 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Funeral D 29a. Certifier It Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. To the Hosp within 24 hox To the Fune completely fi edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end placa, and due to the ceuse(s) and manner stated. 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) 44102 07 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 6 William Renzulli, M.D., 901 Warburton Road, Elkton, MD 21921 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 2 2000

Registrar

DHMH 16 Ray 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** June 3, Paul Herman Campbell 2000 12:30 P.M. /Medical 4a Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 57 Loveland Drive E1kton Ceci1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 11 1934 Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1XDM 2□F 188-26-6806 Yrs. Director 66 Pennsylvania Usuel Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylas peperment of Heelth and Mentel Hygiene. Important: if if then 27 is marked other than "natural", or itema 23a or 28a-f show any Injury orber traumatic event, as we can it among the most terroritied in Maryland Cecil 1 ☐ Yes 2 No **Elkton** Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 57 Loveland Drive 21921 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forcas July, 1958 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes July, 1964 14. Race - American Indian, 11. Merital Stetus Bleck, White, etc. 1 ☐ Never Married 2 X Married to1964 White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Marine Transport 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James A. Campbell Catherine P. Cleck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred C. Campbell / Spouse 57 Loveland Drive 21921 Elkton, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete Pennsylvania 1 ☐ Burlai 2 ☐ Cremetion 3 ☐ Removal from State June 6, West Chester, R.A. Ferris & Co. 4 □ Donetion 5 □ Other (Specify) 2000 21. Signatup of Puneral Septe Decree 22. Name and Address of Facility 21901 Crouch Funeral Home 127 South Main Street North East, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical à metersceris la 10-12 MOS Examiner Due to (or as a consequence of): Examiner burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of): the Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 Vea 2 No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1. Neturel 1 Yes 2 No 2 Accident

The law requires that the death certificate be executed pue P.O. Box 68760, physicien signed by the Records, cata has been signated by page 2 should b certificata Division of Vital

28a-f ahow

3altimore, Maryland 21215-0020

To the Hospitat or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it

10+1 VA

**DHMH 16 Rev 6/95** 

State Registrar

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

William

29b. Signature and title of cartifie

31. Date filed (Month, Day, Year)

6 Could not be determined

Renzoll 32. Registrar's Signature

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

901 Warburton

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1)44107

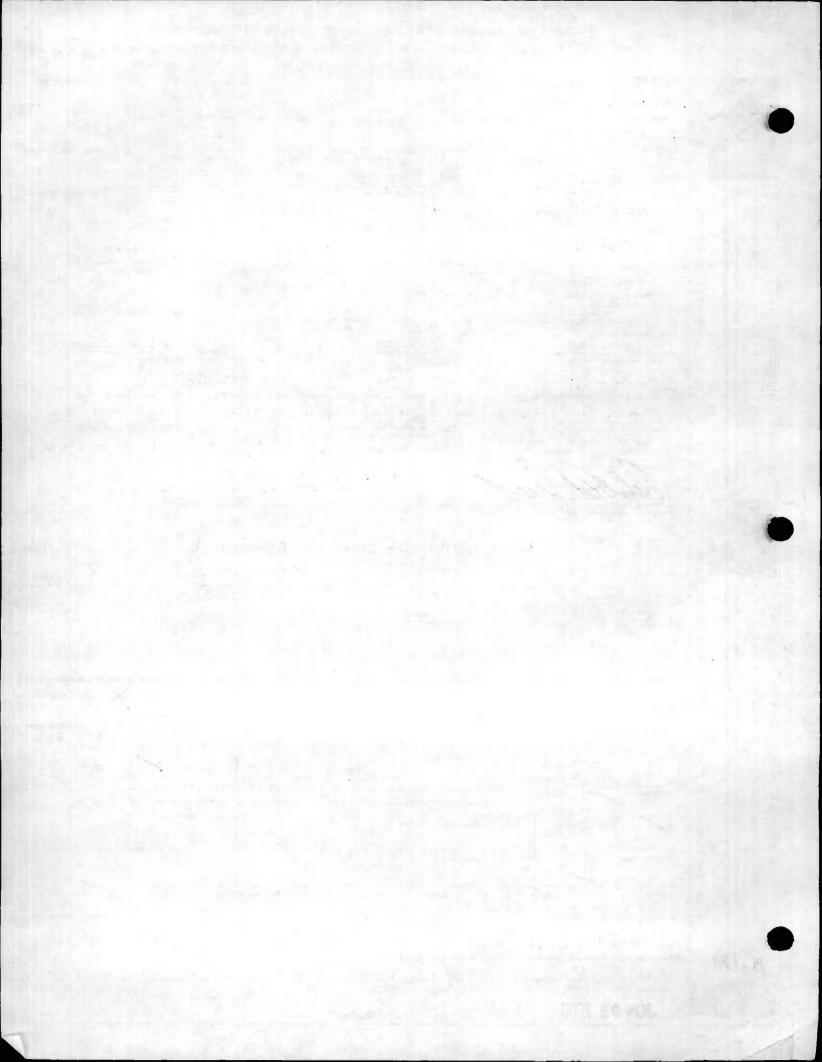
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State)

Rd. Elkton, MD 21921

29d. Date signed (Month, Day, Year)

**ORIGINAL** 

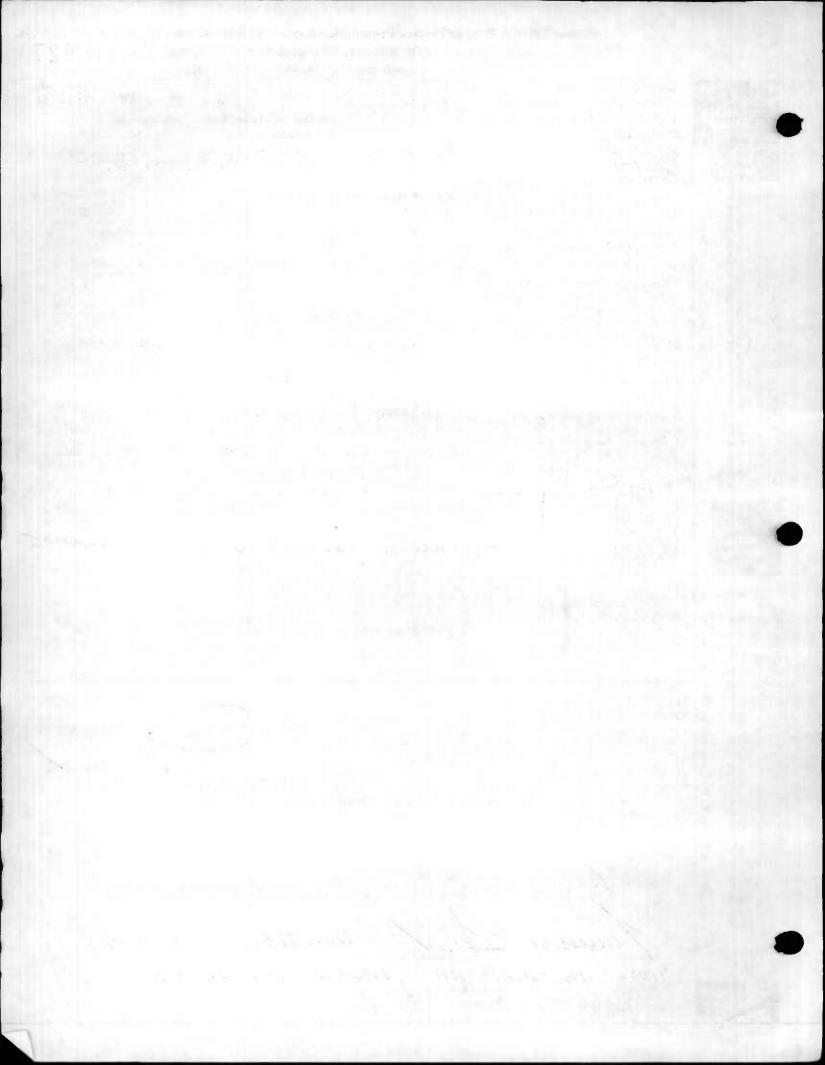


### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 1902

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	h with th	al Dire	10e. Street end Number 501 Main Street	# 124			p Code 2070	7		10g. Citizen of Wi		7
020	within 72 hours efter death with the Marylend iene. 'then "natural", or Name 23s or 28s-f show the Medical Experience must be notified at	by Funeral	11. Maritel Status  1 Never Married 2 Married  3 AWidowed 4 Divorced	12. Wes Decedent Eve Armed Forces? 1°FTYes 2□ No If Yes, Give Yeer or Dates:	or in U,S.			Hispenic Origin? ( pan, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	14. Rece Bleck Specify:	- American , White, etc wh:	
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Baltimore,	permit. Pages 1 en Depertment of Heal Important: If item 2 any Injury or othar once.		4 Donetion 5 Other (Speci	<i>(y)</i>	Glen H / M0077	22. Name e Don	nd Addr alds	ess of Facility on Funer		P.A.		
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Division	5 # F =	Certification:	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined		At home, farm	, street, fector	ry, offica		28f. Location ( City or To	Street end Number wn, Stete)	or Rurel R	oute Number,
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edicai	29a. Certifier Ty Cartifying Pr (Check only 2 Medical Exar	ysician: To the best of m ninar: On the basis of exa end menner steted	aminetion and/o	leath occurred or Investigetion	et the ti	me, dete end plac opinion, deeth occ	ce, end due to the curred et the time,	ceuse(s) and meni dete end plece, an	ner as stete id due to the	ed. e cause(s)
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3	5		30. Name and address of person who	Completed cause of deet	(Item 23e) (Ty	/pe, Print)	De	10/7/3	5	6-5	-00	
	luet		9/05C ML 31. Dete filed (Month, Dey, Year)	SAINTS,	RD	, LA	Inc	2,14	D 20	723		
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Dorothy A. Cook 2000 June 6 1:58pm /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 830 River Road Svkesville Carroll If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) **Funeral** Months Deys Hours 1 □ M 2 🖾 F Yrs 69 Director 212-26-8131 Maryland Usuat Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits 25a-f show with the Maryla 1 ☐ Yes 2 No Director Carroll Sykesville the Medical Examiner must be notifi-10g. Citizen of What Country? 10e Street and Number 10f. Zip Code or thems 23s or 830 River Road United States Funeral 14. Rece - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Illed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: þ 3√2 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Livestock Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surname) Be Pages 1 and 2 should be nent of Health and Mental nd Mental marked o James Vukovan Amelia Kurjaka and a 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 is any Injury or other tra William D. Cook, Jr./Son 830 River Road Sykesville, Maryland 21784 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Cemetery 6-9-2000 Marriottsville, MD 22. Name end Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funerel Service Licensee MO1044 ma 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Intervei Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest **Physician** ARCINOMA /Medical Immediate Cause (Final ECUEREX LOS disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ettending physician and for use as the bunal-tran Due to (or as e consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): signed by the e 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. Be 25. Was case referred to medicel 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Tesidence 8 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homieid 1 | Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiler: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Certifier 29c. License number 29d. Date signed (Month, Dey, Year) Signature and title auteof death (Item 23a) (Type, Print) 30. Name and address of per DAKTHORE, 2109 DIANGH W 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State JUN 0 8 2000 Dependen Registra

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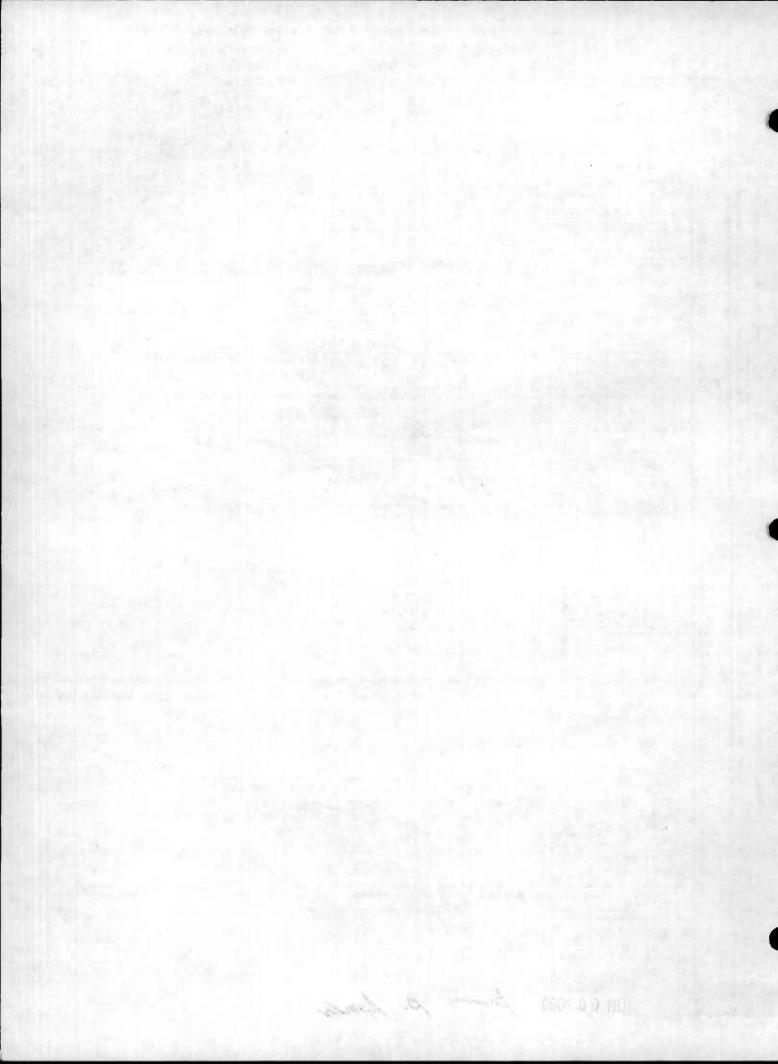
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Funeral Director		Sex 7. Age (In)	rs. last birthd Yrs	Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Februar	y 18,192	9. Birthplace (State or Foreign 5 Maryland
Du B sa	10a. State 10b. County	10c.	City, Town o	r Location				10d. toside City Limits
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or 28s-1 s be notified	10e. Street and Number			10f, Zip Code			I0g. Citizen of WI	nat Country?
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urs after dea	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 X No If Yes, Give Year or Dates:	n U,S. 1	3. Was Decedent of H Yes, specify Cub  1 Yes 2 X No		ecify Yes or No- Rican, etc.)		- American Indian, Whita, etc. White
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Depa Impo any tr	21. Signature of Funeral Service Licer	Brady		Andrew K. 40 East Al	Coffman l ntietam S	Funeral treet, H	Home, In	nc. vn, Maryland217
	23a. Part1. Enter the disease, or com shock, or haart failure. List only	plications that sused the d	eath. Do not	entar the mode of dyin	ng, such as cardiac	or respiratory ar	est,	Approximate Interval Between
The law requires that the death certificate be executed the law requires that the death certificate be executed page 2 should be detached for use as the buriat-transit completed by Physician/Medical Examiner	Cause (Disease or Injury that initiated events resulting in death) Lest		CVLAR o (or as a con o (or as a con	FIBRIL sequence of):	ATION			
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The I						1 🗆 Y	es 250No	1 ☐ Yes 2 ☐ No
Physician: The lave this certificate has rail director, page 2: To Be Comp.	25. Was case referred to medical examiner?				26. Placa of Deat	h (Check only o	ne)	
Physician: this certific ral director,	1 Yes 250 No	Hospital: 1 Dunpatient 2	ER/Outpa	tient 3□ DOA Oth	ner: 4 Nursing Ho	me 5 Rasid	ence 6 Otha	(Specify)
To the Hospital or Attending Physicians 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	27. Manner of Death  1 Naturat 5 Pending  2 Accident investigation  3 Sulcide 6 Could nice death	9 28a. Placa of Injury - A	yst rk? Yes 2 No	28d. Describe how Injury occurred  28f. Location (Street and Number or Rural Route Number City or Town, State)				
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he Hospitu in 24 hours he Funera pletely fille	29a. Certifier 1⊠ Certifying Ph (Check only one) 2 Medical Exam	ystctan: To the best of my ininer: On the basis of axam and manner stated.	cnowledge, di ination snd/o	aath occurred at the ti r investigation, in my c	ma, date and place, ppinion, death occur	and dua to tha cred at the time, c	ause(s) and man late and place, as	nar as stated. nd dua to tha cause(s)
Within To the comp	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed	(Month, Day, Year)
	m. 6 80 052323						6/	7/2000
	30. Name and address of person who	complated cause of death (I		0e, Print) 94146 L	IETBLIR	ur. Di	ux HA	a m021742
State	31. Date filed (Month, Day, Year)	32. Registrar's Si	-	14146	LICI ENTO	VI-4 1/1	-E 11/1	1112
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Metropolitan Funeral Service, Inc. 21. Signeture of Funeral Service License rldo 5517 Vine Street Alexandria, VA 22310 23a Bernt. Enter the disease, encomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician Cholangio Carcinoma

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 Funeral Director: After this certifical letaly filled in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 26b. Time of 28c. Injury et Work? 1 Salatural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a, Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) Canene werns, MD D52830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestgate Road, #300, Amapolis, mo 21401 Eanine Werner

State Registrar 31. Date filed (Month, Day, Year) JUN 1 5 2000

1

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Bed. No.

di <u>an in</u>	Certificate of Death	Reg. No.	19031						
Physician		Date of Death Month Day Ye							
/Medical	RUTH JOANN ELLIOTT  4a Facility Name (If not institution, give street and number)  4b. City, Town, or Loca	JUNE 3 20 Ition of Death 4c. County of E							
Examiner									
Funeral	WASHINGTON COUNTY HOSPITAL  S. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year  If Under 24 Hrs. 8		IINGTON  Birthplace (State or Foreign Country)						
Funeral Director		(Month, Day, Year) EB. 10, 1933	MARYLAND						
show Mail	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits						
the Maryla 28=1 sho notified at	MARYLAND WASHINGTON HAGERSTOW	JN	1⊠Yes 2□No						
vith the Ma or 28a-fs be notified	10e. Street and Number 10f. Zip Code	10g. Citizen of Wha	t Country?						
if w	11 WEST BALTIMORE STREET, APT. 101 21740	U.S.	Α.						
d 21215-0020 filed within 72 hours after death with the Maryland Hydione. ther than "patural", or items 23a or 28a-1 show wit, the Medical Examination must be incomed at a Completed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent of Hispanic Origin? (Specification of the properties) of the properties of the p	fy Yes or No- cen, etc.)  14. Race - / Black, V Specify:	Americen Indian, Vhite, etc.  WHTTE						
2 hor	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Busine							
1 21215-0 ed within 72 ho ygiene. wer than *naturin, in Malen Completed	(Specify only highest grade completed)  (Give kind of work done during most of working lifa. DO NOT use retired)  (Give kind of work done during most of working lifa. DO NOT use retired)								
212 d with	12 CARE GIVER	ADULT C	ARE GROUP						
/land 2 /land 2 /land 2 /land be filed //ental Hygi //ent	17. Father's Name (First, Middla, Last)  18. Mothar's Name (i	First, Middle, Malden Surname)							
arylanoshould be should be in marked or umatic ave	DAVID W. LITTON SR. MILDRED R	UTH ROWE							
- CI 00 00 E	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addrass (Street and Number or Rural F								
	CHARLES W. ELLIOTT SR./SON 14002 WEAVER AVE., MAUG								
0 82 2 2	20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stata	Date 20c. Location - City	or Iown, State						
timent tant: hag		7/00 HAGERSTOV	N, MARYLAND						
Baltim permit. Pag Department Important: I any Injury once.	Paul M. Dean BAST FUNERAL HOME B	606 Old Nationa Boonsboro, Maryl							
The same of the sa	23a. Part1. Entar tha disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or r shock, or haart failura. List only one ceuse on each line.	respiratory arrest,	Approximate Interval Between						
Physician / /Medical Examiner	Immediate Causa (Final disease or condition a. Cercival Vasular accident resulting in death)	+	24 hows						
- I	Due to (or as a consequence of):								
8760, ate be executed hysician and the burial-transit	b								
68760, rificate be executed or physician and e as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events Due to (or as a consequence of):								
68760, filicate be exposition to physician as the burial edical Exposition of the following the foll	Cause (Disaase or Injury that initiated events Due to (or as a consequence of):								
N O O O O	d								
O. B. D. Brown the att hed to	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did tobacco uss contril	buts to the causs of death?						
Records, P.O. Box The law requires that the death certifies been signed by the attending page 2 should be detached for use a completed by Physician/M	Metaslafii Breast Cancer	1 □ Yes 2 1 No 3	□ Probably 4 □ Unknows						
Cords v requira been sig		24a. Was an autopsy performed?	4b. Wara autopsy findings available prior to						
A Record The law require cate has been si page 2 should Completed		,	completion of ceuse of death?						
The it atterns atterns page		1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☐ No						
	25. Was cesa raferred to medical 26. Place of Death (	Check only one)							
of Vital of Vital hysician: hysician al director, p	examiner? 1 Yas 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Othar (	Specify)						
On of on of aling Phy Attenties funeral d	1 Netural 5 Pending (Month, Day Year) Injury Work?	d. Dascribe how injury occurred							
Si S	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)	f. Location (Street and Number of City or Town, State)	or Rural Route Number,						
	29a. Certifier Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, date and place, and	d due to the cause(s) and manne	ar as statad.						
he Hospi in 24 hou he Funer pletely fill	(Check only one)  2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date and place, and	que to tha cause(s)						
To the within To the comp	29b. Signature and title of certifier 29c. License number	29d. Date signed (A	Nonth, Day, Year)						
	100 H52265	June 4	2000						
	30. Name and address of person who completed ceuse of death (Hem 23a) (Type, Print)  Dr Winkelman, 24 N. Walnut, St Hagers	town Mar.	hne						
State	31. Date filed (Month Pay Year) 2000 32 Amistraci Signature 4.								

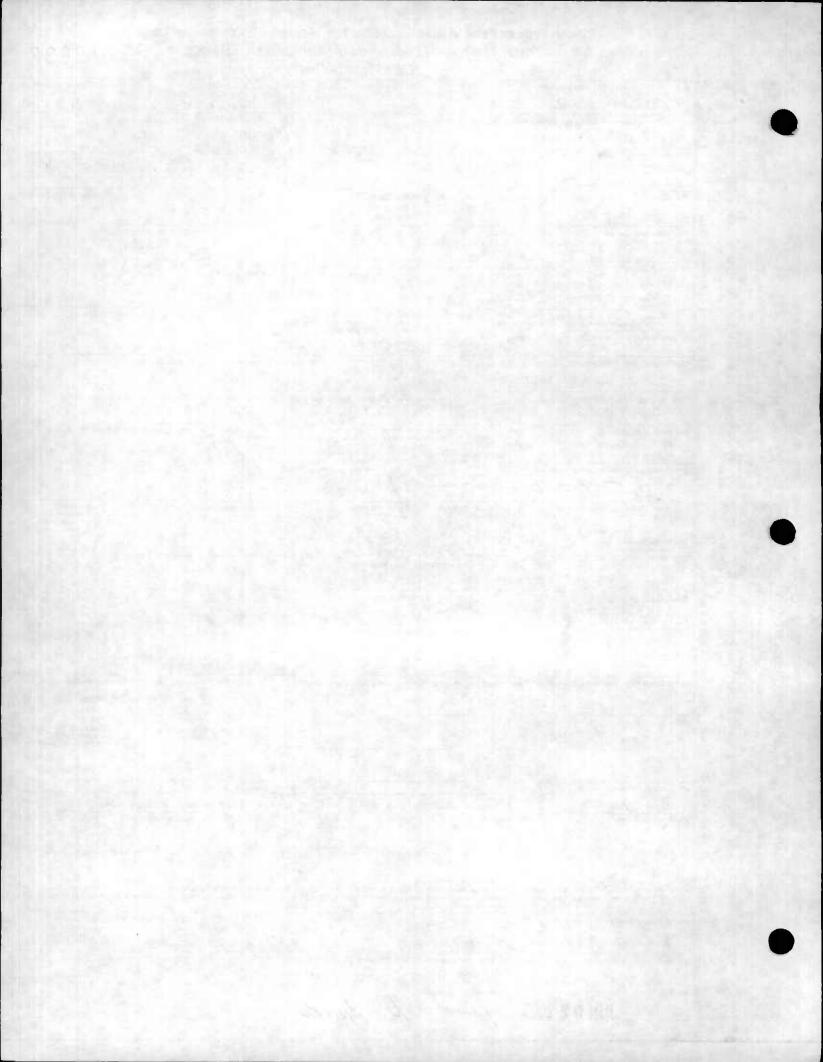
DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 00 19032

											Reg. No.		
hysician	1. Decedent's PET	Name (First, Middle ER DONA		RNESS	CD					2. Date of Do Month	Day	Year	3. Time of Dea
/Medical		ne (If not institution			SR.		4	b. City, To	wn, or Le	ocation of Dear		ty of Death	
xaminer	17,000	TOWN POIN	111-74-20					CHES	APE	KE CIT		CIL	
eral	5. Social Securi		6. Sex 12 M 2 F		s. last birthdey,	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth ay, Year) 14,1914	9. Birth	place (Stete or Fo
tor	097-10- Usual Residence			86	Yrs.					MARCH	14,1914	COR	NING, NY
	10a. State	10b. County		10c. 0	City, Town or L	ocation							10d. tnside City Li
ctor	MD	CECIL			CHESAP								1 ☐ Yes 21
Directo		Number OWN POINT	Γ ROAD			10f. Zip (	Code 1915				10g. Citizen of What Country? U.S.A.		
y Funeral		Married 2 Marri	ied Amed I	ecedent Ever in Forces? s 2 No Give	U,S. 13.	Was Decede If Yes, speci			gin? (Sp	Specify Yes or No- to Rican, etc.)  14. Race - American Indian, Bleck, White, etc.  Specify: WHITE			
ed by		d 4 ☐ Divorced	Yeer or	Dates:	16a Dece	edent's Usuel	Occupa	ation			16b. Kind of		
Completed	Flementery/S	Specify only highes Secondary (0-12)	st grade completed	d) (1-4or 5+)	(Give	(Give kind of work done during most of working life. DO NOT use retired)							
Com	12			(1 401 01)	ELECT	RICAL	CON					RICAL	,
BB	17. Fathers Na	me (First, Middle, I T RANDOL]		3						e (First, Middle DYSON	, Meiden Sum	eme)	
To					19b. Mait	ling Address	(Street				ber, City or Tow	n, Stete. Zi	ip Code)
n and information in the state of the transit of th		19a. Informant's Name/Relationship (Type, Print) ALICE FURNESS  19b. Maiting Address (Street and Number or Rural Route Number, City or Town, 1779 TOWN POINT ROAD, CHESAPEAKE CITY											
	20a. Method of		2 Domovel from	20b.	Place of Disp	osition (Nem	e of her plec	e)	TI	Date INE 6.	20c. Location	n - City or T	own, State
		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  DELAWARE VETERANS MEMORIAL CEMETERY  JUNE 6, 2000  BEAR								, DE			
	21. Signature of	of Funeral Service I	Licensee	On	2 M	2. Neme end IEALEY	FUN	ERAL	HOM	ES			
	I de	ler the disease, or		)6							DE 1980	5	Approximete
	disease or con resulting in dea	use (Final dition uth)	a. An	Due to	lic L (or as a conse	equence of):	al	Sele	105	is		1	years
Examiner	disease or con resulting in dea	dition  at conditions, to immediate Inderlying e or injury ents	a	Due to	(or as a conse	equence of):	rol	Sela	205	is			years
n/Medical Examiner	disease or con resulting in dea Sequentially lis if any, leading cause. Enter L Cause (Diseas that initiated ev resulting in dea	dition  at conditions, to immediate Inderlying e or injury ents	c	Due to	(or as e conse	equence of):				23b. Dic	,		
VMedical Examiner	disease or con resulting in dea Sequentially lis if any, leading cause. Enter L Cause (Diseas that initiated ev resulting in dea	dition ith)  st conditions, to immediate Inderlying e or injury ents th) Last	c	Due to	(or as e conse	equence of):				23b. Dic	l tobacco uas o Yss 2□ No		to the cause of de
by Physician/Medical Examiner	Sequentially lis if any, leading cause. Enter L. Cause (Diseasthat initiated ev resulting in dea	dition ith)  st conditions, to immediate Inderlying e or injury ents th) Last	c	Due to	(or as e conse	equence of):				23b. Dic 10 24a. Wa	,	3 Pro	Obably 4 Unk
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cation: To Be Completed by Physician/Medical Examiner	disease or con resulting in deal resulting in deal side and resulting in deal side and resulting in deal resulting in de	eferred to medicate of the conditions of the conditions, to immediate inderlying e or injury ents of the condition of the con	d.  d.  Hospital: 1  gation not be 28e. Ple buil  g Physician: To the Examiner: On the	Due to  Due to  Due to  death but not re  e of Injury onth, Dey Year)  ce of Injury - At Idding, etc. (Special	(or as a consection of the section o	equence of):  underlying ca  ent 3 DO. of 28 M treet, fectory,	A Other Book Injury World 1, office at the time in my of	26. Place 96: 4 No. 7 at 7 Yes 2 Inc., dete ar	e of Deel	23b. Did 1/A 24a. Wa per 1 Check only one 5 A Res 28d. Describe 28f. Location City or To	Yes 2 No s an sutopsy ormed?  Yes 2 No one) sidence 6 Co how injury occ (Street and Nul wm, State)	24b. V e C c c o o ther (Spec	Vere autopsy finding variable prior to completion of cause if death?  Yes 2 No  ifly)  rel Route Number, stated to the cause(s)
cation: To Be Completed by Physician/Medical Examiner	disease or con resulting in deal resulting in deal sit any, leading cause. Enter L. Cause (Diseas that initiated ev resulting in deal resu	eferred to medicate of the conditions of the conditions, to immediate inderlying e or injury ents of the condition of the con	d.  d.  Hospital: 1  gation not be 28e. Ple buil  g Physician: To the Examiner: On the	Due to  Due to  Due to  death but not re  de of Injury  onth, Dey Year)  ce of Injury - At Idding, etc. (Spector)	(or as a consection of the section o	equence of):  underlying ca  ent 3 DO. of 28 M treet, fectory, th occurred a nvestigation, 29c.	A Oth- Bc. Injuny Worl 1   , office at the tim in my of	26. Place 9: 4 No y at X7 Yes 2 Ine, dete ar	e of Deel ursing Ho No	23b. Did 1/A 24a. Wa per 1 Check only one 5 A Res 28d. Describe 28f. Location City or To	Yes 2 No s an sutopsy ormed?  Yes 2 No one) sidence 6 Co how injury occ (Street and Nul own, Stete) e ceuse(s) end , date and place 29d. Date sig	24b. V e C c o o ther (Special recommend) meaning as e, and due	Vere autopsy findi vailable prior to ompletion of caus f death?  Yes 2 No
refused in by the funeral director, page 2 should be detached for use as the burial-transit edical Certification: To Be Completed by Physician/Medical Examiner	disease or con resulting in deal resulting in deal sequentially list if any, leading cause. Enter L. Cause (Diseas that initiated ev resulting in deal resul	eferred to medicate of the conditions of the conditions, to immediate inderlying e or injury ents of the condition of the con	d.  d.  Hospital: 1  gation not be 28e. Ple buil  g Physician: To the and ma	Due to  Due to  Due to  Due to  death but not re  de of Injury  onth, Dey Year)  ce of Injury - At Idding, etc. (Spector)  the best of my kit basis of examinanner stated.	(or as a consector as	equence of):  underlying ca  ent 3 DO. of 28 M treet, fectory, th occurred a nvestigation, 29c.	A Oth- Bc. Injuny Worl 1   , office at the tim in my of	26. Place 9: 4 No y at K? Yes 2 Ine, dete an pinion, dese	e of Deel ursing Ho No	23b. Did 1/A 24a. Wa per 1 Check only one 5 A Res 28d. Describe 28f. Location City or To	Yes 2 No s an sutopsy ormed?  Yes 2 No one) sidence 6 C how injury occ (Street and Nui wm, Stete) e ceuse(s) end h, date and place	24b. V e C c o o ther (Special recommend) meaning as e, and due	Vere autopsy find vailable prior to ompletion of caus of death?  Yes 2 No



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9033 Amend item #2, per F.H.,6/6/00,BG Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yaar **Physician** Furbush 4b. City, Town, or Location of Death Martha 3,2000 /Medical 1:40 AM 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Salisbury Center; Genesis ElderCare Salisbury, Md. Wicomico If Under 1 8. Data of Birth (Month, Day, Year) 06/15/1925 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 20F Yes 221-14-0959 74 Delaware Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Somerset Eden 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 32138 Jones Road 21822 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Hygiens. Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) 12 Restaurant Waitress FURBUSH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Health and Mental Rem 27 is marked or Louis Willey Veda Dean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 32209 Bonhill Drive, Salisbury, Md. 21804 ELTA Trina Lowe/Daughter 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its any injury or of MARTHA Allen U. M. Cemetery 6/6/2000 Allen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21: Signature of Funeral Service License 22. Name and Address of Facility
Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, Md. RNAW 21853 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner u or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue **bunel-tran** Box 68760. ettending physicien for use as the burie 70 Physician/Medical the Due to (or as a consequence of) US0 88 signed by the et Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun

State Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1104 HEALTHWAY DR., SALISBURY, MD

WILLIAM ROBINS, 31. Date filed (Month, Day, Year) M.D 32. Registrar's Signature

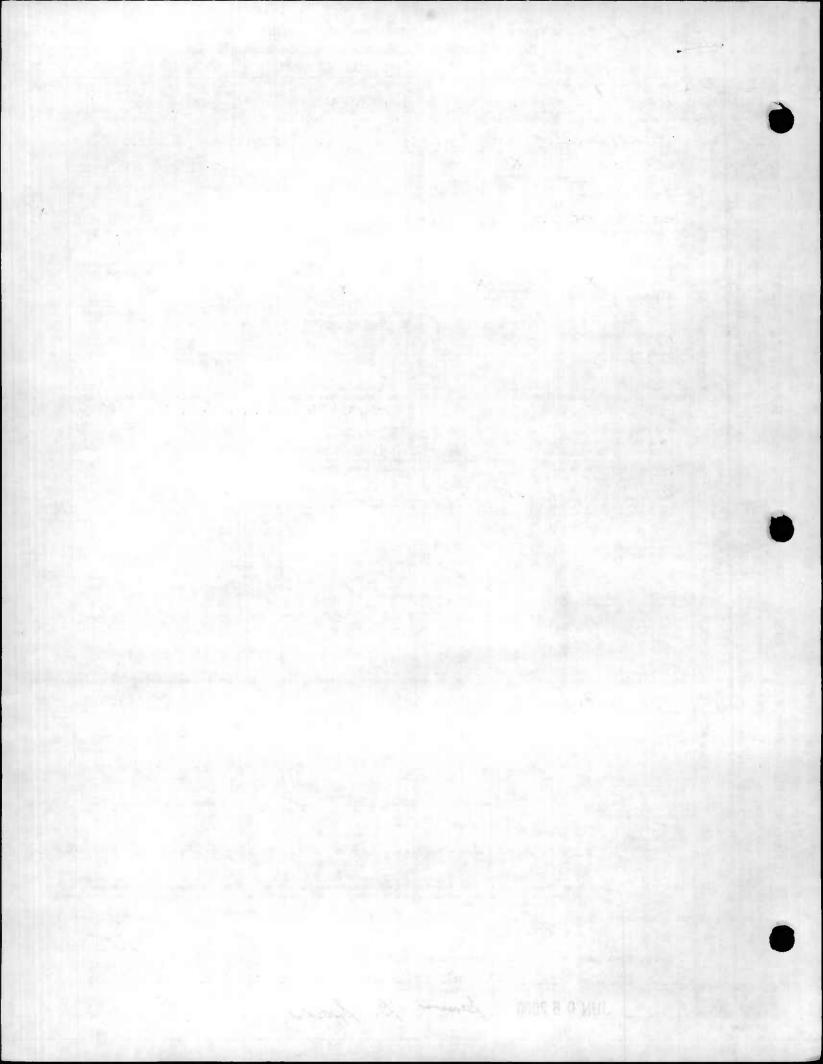
JUN 0 6 2000

1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

29c. License number

ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

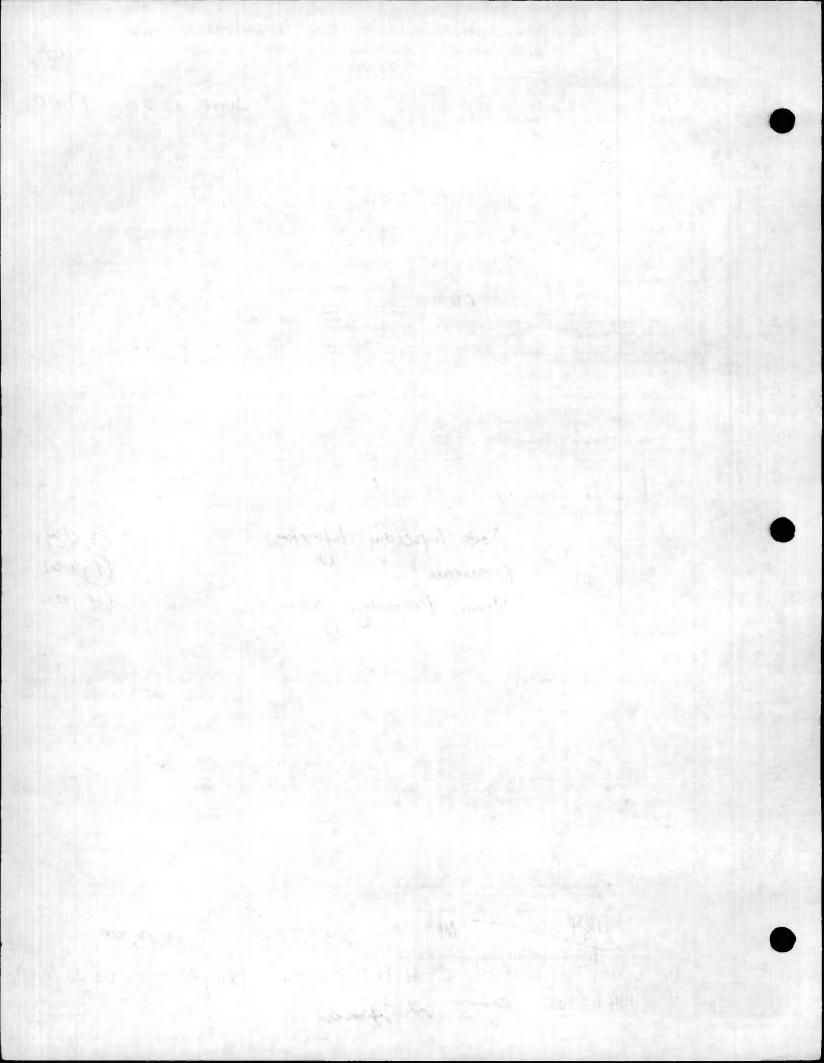


# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	Physician	Decedent's Nama (First, Middle	0	C	epartment Certificate			2. Data of De	Reg. No.	Vans	9034 Time of Deeth	
	/Medical Examiner	Herbert  4a Fecility Nama (If not institution		rver		4b.	City, Town, or Lo	JUNE ocation of Death			1.00	
100	Funeral Director	Washington 5. Social Security Number 173-03-3763	-C+ -C-	pital (In yrs. last birthd 81 Yrs	Months	1 Year   If	lagerto Tunder 24 Hrs. Hours Min.	8. Deta of Birt (Month, Da Nov 2		shingt  9. Birthplace ( Country)  Waynes	on (State or Foreign sboro, PA	
	yland M M	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location					10d. In	nside City Limits	
	the Maryle 25a-f sho notified at rector	MD Washi	ngton	Clear	Sprin	12				11	□ Yas 2√ No	
	or 25a-f s be notified Director	10e. Street and Number			10f. Zip				10g. Citizen of W	hat Country?		
		13320 Grube				21722			US			
020	st, or tems 23 Examiner must by Funeral	11. Marital Status  1 Never Merried 2 Marri  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 12 Yas 2 N If Yas, Giva Year or Dates:	0	If Yas, speci		anic Origin? (Sp Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Specify:	a - Amarican Ind k, Whita, atc. Whit		
21215-0020	ed within 72 ho ygiene. ygiene. it. the Medical.	15. Decedent (Specify only highes Elementary/Secondary (0-12)	Education	16a. De (G			on ing most of work	ing	16b. Kind of Bus			
		1.2 17. Father's Name (First, Middle, I	est)		machi			a /First. Middle.	machin		1 mig	
Maryland	Mental H mined off affice ever To Be	Samuel	Lane	Ga	rver		Nellie			Spe	ck	
ary	shou omen omen	19a. Informant's Neme/Relationsh		19b. M	eiling Address	(Street and	Number or Run	al Route Numbe	er, City or Town,			
2	and 2 patth a 127 ls	Larry & Garv	er	603	603 Clayton Avenue			Wayn	esboro	PA 17	268	
Baltimore	Pages 1 sent of He mt: If Item ry or offi	20a. Method of Disposition  1X		novel from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Green Hill Cemete				Data	Waynes		PA	
Balti	permit. Departm Importa any inju	21. Signature of Funeral Service I		Greek	22. Nama and Addrass of Facility Grove-Bowersox Funeral Home, Inc. 50 S Broad ST Waynesboro PA 172							
s, P.O. Box 68760,	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit standard by Physician/Medical Examiner	23a. Pant J Enter the disease, or shock, or heart tailura. List of the shock, or heart tailura	a. A onfi	Dua to (or as a convenue Dua to (or a) convenue	sequence of):  Sequence of):  Sequence of):	Infar for	sefor.		obacco use con	Onsi	cause of death?	
al Records,	3 0 CA DT								an autopsy med? /as 2 No	available complet of death	utopsy tindings a prior lo tion of causa ?	
Vital	Physician: this carific ral director,	25. Was casa refarred to medical examiner?	Hospitel:			Other	6. Place of Deet					
o	fer this uneral di	1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury	· · · · · · · · · · · · · · · · · · ·	e of 28	Sc. Injury at Work?			dence 6 Other			
Division	To the Hooptial or Attending Physician: The is within 24 hours after death. To the Furess Director: After his certificate ha completely fland in by the funeral director, page Medical Certification: To Be Com-	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	t be One Disease ( lei-	ry - At homa, farm (Specify)	M 1 Yas 2 No homa, farm, street, factory, office 28f. Locat					ocation (Street and Number or Rural Route Number, Sity or Town, State)		
	n 24 hours n 24 hours ne Funeral pletsly fille edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of xaminer: On the basis of a end manner stat	examination end/o	eath occurred e r invastigation,	t the time, in my opini	date and place, ion, deeth occurr	end due to the red et the time,	cause(s) and mai date end plece, a	nner es stated. and due to the o	cause(s)	
9	To the within To the comple	29b. Signature and title of prints		WD.	I	License no	288		29d. Data signed	200		
	State Registrar	30. Name and address of person value of the state of the	12821 32. Registrar	Oak	pe, Print)	Aut	enue	Hag.	erstou	un M	aryland	

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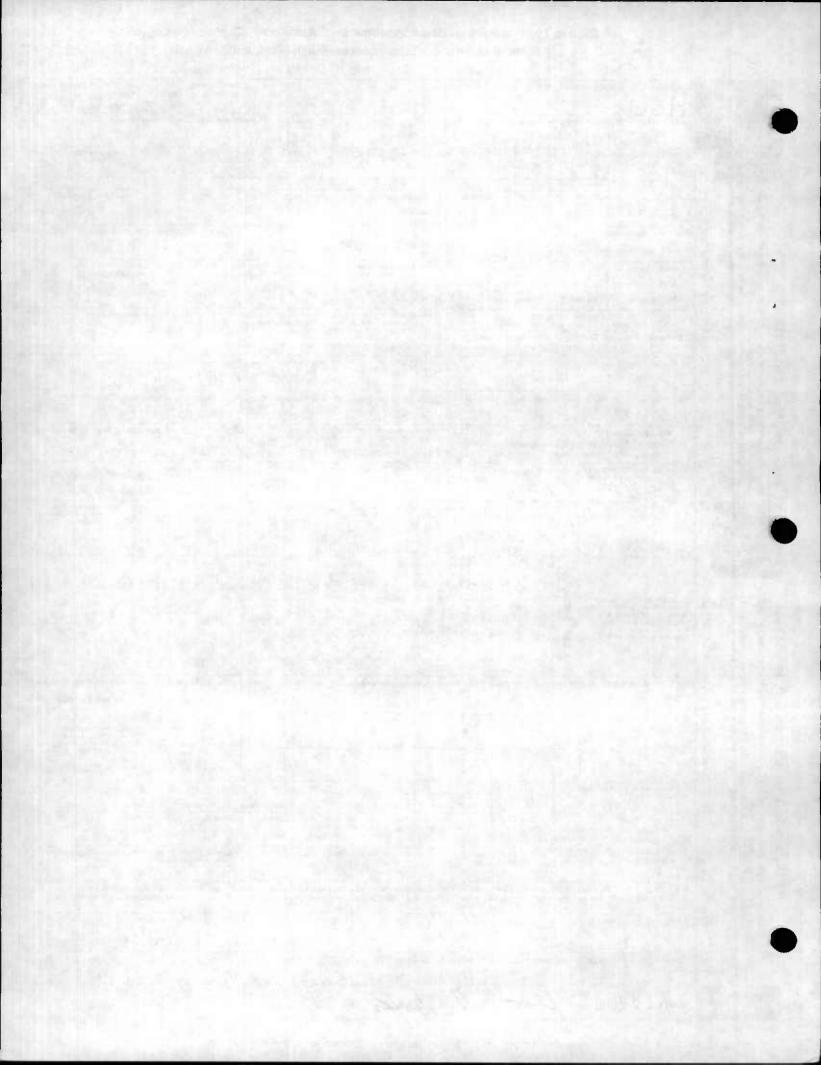
Herbert Lane Garrer



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State of Maryland / Department of Health and Mental Hygiene 00 19035

			C	ertificate of	Death		Reg. No.		12000
Division	1. Decedent's Name (First, Middle, Las	st)	0			2. Date of Dea	ath Day	Yaar	3. Time of Death
Physician /Medical	Hishlee		900	oding		June	. 1"	000	12:18 A.M
Examiner	4a Facility Name (If not institution, give	street end number)	11	J	4b. City, Town, or Lo	ocation of Death	4c. County	of Death	
	The Johns +	topkins	HOSPI	tal	Baltin	ore			
Funeral Director	5. Social Security Number 6. St 229-63-7969	ax 7. Aga ( □ M 2X F	In yrs. lest birthde	Months   Days		8. Date of Birt (Month, De May 3,	1990	9. Birtho Coun Vir	lace (State or Foreign try) ginia
2	Usual Residenca of Decedent								
Manylar a-f show Ureata	Virginia Fauquie		Oc. City, Town or Bealeton					1	0d. Inside City Limits 1 ☐ Yes 2 1 No
ath with the Manylan 23s or 28s-1 show ust be notified at rai Director	10e. Street and Number 6254 Goulding Cour	rt		10f. Zip Code 22712			10g. Citizen of What Country? U.S.A.		
020 urs after dea if, or items ten ner m by Fune	11. Marital Stafus  12_Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev. Armed Forces? 1  Yes 2 No If Yas, Give Year or Detes:	er in U,S.	3. Was Decedent of If Yes, specify Cut  1 ☐ Yes 2€XNo	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, atc.)		e - Americ k, White, o	
1 21215-0020  od within 72 hours at ygiene.  or than "natural", or it, the western Event Completed by F	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	16a. De	cedent's Usual Occu	pation during most of work ed)	ing	16b. Kind of Bu	isiness/Inc	Justry
within within the then the the then the the then the the then the	Elementary/Secondary (0-12)	College (1-4or 5+)		o. <i>DO NOT</i> use retire tudent	ed)		Public	Schoo	0.1
d 2 Hygie ther the Co	17. Father's Name (First, Middle, Last)		8	tudent	18. Mother's Nem	e (First Middle			71
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Maryis 2 should and Mer is marke sumatic To	19e, Informent's Neme/Relationship (7				t end Number or Rur				Code)
4 6 6 5	Michael Gooding/fa	ather			g Court, Be				
0 8 2 2 5	20e. Method of Disposition  1 △ Burial 2 □ Cramation 3 □  4 □ Donation 5 □ Other (Specify		cemetery, c	sposition (Neme of remetory or other ple View Ceme		Date 5/8/2000	20c. Location - Warre		, Virginia
Baitime permit. Pag Department Important: It any Injury o	21. Signature of Funeral Service Licen	MgQmne	0	22. Name and Addr Moser	ess of Facility FuneralHor	me Inc.	233 Bro Warrent		
	23a. Part L Enter the disease, or comp shock, or heart fellure. List only	Dications that caused the	e death. Do not	enter the mode of dy	ing, such as cardiac	or respiratory ar			Approximate Interval Between Onset end Deeth
Physician /Medical	Immediate Cause (Final disease or condition	1114	Desni	Ratory	Distres	5.	ndron	1.0	3 / 2115
Examiner	resulting in death)	IN CIT OF	401	Saays					
od sit		b. Complia	ation	of pone	Marro	w tro	unspla	nti	2 1105
x 68760, erificate be executed ling physician and is as the bunist-transit Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	· Acute	e to (or as a cons	phocyt	ic heu	llemi	a		5 years
M sentit	resulting in death) Last	d							
death of attents ad for us	Dad II Other classificant and distance				i- 8-41	DON DIA		adalbaria da	the same of death ?
P.O. du by the detach	Part II. Other significant conditions co	ontributing to death but i	not resulting in the	e underlying cause g	ven in Part I.		23b. Did tobecco uss contributs		bably 4 Unknown
requirements							an autopsy rmed?	avi	ere autopsy findings ailabla prior to mpletion of causa death?
VITAI Relacionario de la lacera de lacera de la lacera de lacera del lacera de lacera del lacera de lacera del lacera de lacera						10%	res 2□No	10	Yes 2 No
Altai clan: entifica setor, p	25. Wes case referred to medical				26. Place of Deal	h (Check only o	ine)		1
- X 50 5	examiner?	Hospital: 1 Inpatient	2 ER/Outpat	tient 3 DOA	ther: 4 Nursing Ho	ome 5 Resid	dence 6 Oth	er (Specif	y)
VISION OF Attending Physical death. Sector: After this by the funeral of iffication: To	27. Manner of Death  1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Y	(ear) 28b. Time Injur	y We	ory at ork? ☐ Yes 2 ☐ No	28d. Describe	now injury occur	red	
DIVISION C but or Attending P rs after death. el Director: Attert led in by the funers Certification:	3 Suicida 6 Could not be 4 Homicide determined	28e. Placa of Injury building, etc.	- At home, term, (Specify)	street, factory, office		281. Location (S City or Tox		er or Rure	ol Route Number,
Division o  To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral  Medical Certification: 7	29a. Certifier 1 Certifying Phy (Check only one)	ysician: To the best of r liner: On the basis of ex and manner state	camination end/or	eth occurred at the t investigation, in my	ima, dete and plece, opinion, deeth occur	and due to the red at the time,	cause(s) and ma date end place,	nner es si and due to	lated. the ceuse(s)
Me omple	29b. Signatura and title of certifiar				se number		29d. Date signe	d (Month,	Day, Year)
F \$ F ō	) K-	Chan -		5	00545	3	6/4/0	6	
	30. Name and address of person who o	completed cause of dea	th (Item 23a) (Typ	pe, Print)	005452 spital 60		10.5-	BAH	imsra MD
- 0	Karen SchnEiD 31. Date filed (Month, Day, Year)	ラドス J 0 I	Selonatura	KIN2 HO	De 101 PC	10 N.W.	itest	d	1001
State Registrar	JUN 1 5 2000	Serera /	9 600	uls					



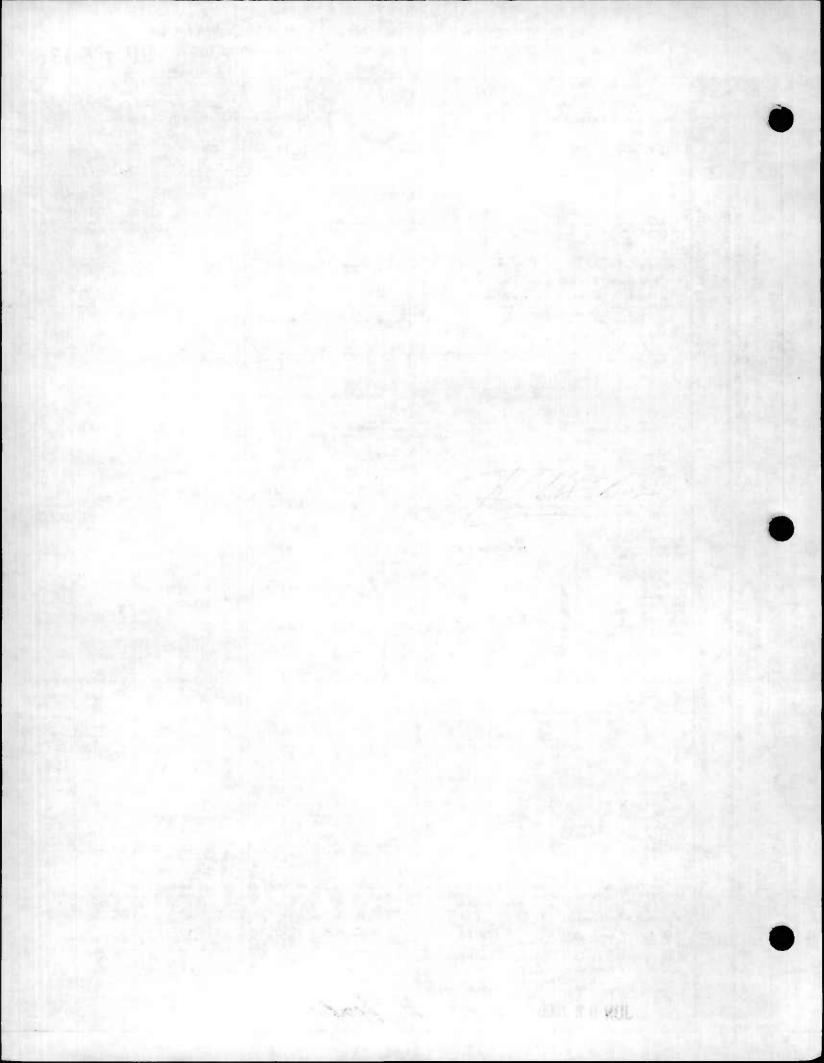
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month Yaar **Physician** CHARLES L. 15:30 , m HALL May 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SunBridge Care & Rehab. for Elkton Elkton If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) 5-2-1919 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 10M 20 F Yrs Director 221-14-6795 Delaware Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or heme 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yas 2 No Director Cecil Md. Warwick 10s. Street and Number 10f. Zio Code 10g. Citizen of What Country? P.O. BOX 45 21912 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yas 212 No If Yes, Giva Year or Datas: 21215-0020 White 1 ☐ Yas 2 ☑ No Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hyglene. Important: If Item 27 is merked other than "natienty lightly or other treumetic event, the Medias ORGE. Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Auto Repair/Service 12 Maryland 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Edward Hall Katie Grace 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Norman Collins 375 Chickory Way, Newark, DE. 19711 Baitimore, 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Barratt's Chapel Cem.6-5-00 Frederica, DE 4 ☐ Donation 5 ☐ Other (Specify) DANTELS THUTCHISON FUNERAL HOME 21. Signature of Funaral Service License 212 N. Broad st., Middletown, DE. 19709 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Tist only one cause or each line. **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical · Recurrent ventricular arrhythmies Lxaminer Dua to (or as a consequence of Examiner ardio my open th physician end s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Box 68760, AS CUB Physician/Medical Dua to (or as a consequence of): usa as rolemia P.O. 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 10 Yes 2 No 3 Probably 4 Unknown signed t Records, þ Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? certificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vitai Attending Physician: 25. Was casa refarred to medical axaminer? 80 28. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 2 No Medical Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attanding within 24 hours ettar death.

To the Funeral Director: Afta completely filled in by the fune 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 ☐ Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier Let Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and titla of pertifier 29c. License number 29d. Data signed (Month, Day, Year) D0035779 mo. June 1, 2000 Mollensham 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) wibruce Obenshain, M.C. 251 S. Go hemia Ave., Cecilton, Md. 21213 V.E 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

Registrar

JUN 0 2 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Freida M. Hastings 1, 2000 1:30 PM June /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner 1203 Old Telegraph Rd. Warwick If Under 1 Year Months Days If Under 24 Hrs 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** Hours 1□ M 2♥ F Yrs. 217-09-3889 81 Director 17,1919 Secretary, MD Usual Rasidence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 25a-f show must be notified 1X Yes 2 No New Castle Co. Newark Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 502 Willa Road 19711 U.S.A. flems 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian, 11 Meritel Status Black, White, etc. Pages 1 and 2 should be liled within 72 hours aher next of Health and Mental Hygiene, next of Health and Series of the marked other than "natural", or its any or other traumatic event, the Medical Examinators are or other traumatic event, the Medical Examination 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: þ Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Own Home Homemaker Baltimore, Maryland 18. Mother's Name (First, Middla, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Bessie Dean William T. Havward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Susan M. Smith-Daughter 502 Willa Rd. Newark, DE 19711 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Mathod of Disposition Date 20c. Location - City or Town, State June 6, 1 Burial 2 ☐ Crametion 3 ☐ Removal from Stata Department of Important: If any injury or Gracelawn Memorial Pk. 2000 New Castle, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Liouville 22. Name and Address of Facilit Spicer Mullikin Funeral Home 1 Harvey C. Smith, Jr. DuPont Pkwy. New Castle, DE 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition rasulting in death) /Medical Alzheimers approx 4 yrs Examiner Due to (or as a consequence of) Examiner inding physician and use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as e consequance of) Box 68760. Physician/Medical Due to (or as a consequence of): P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco was contributs to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 8 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Be Completed 24a. Was an autopsy performed' certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case ratarred to medical 26. Piace of Death (Check only ona) Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 MOthar (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Affer Division 1 Natural 5 Pending investigation Injury after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C completely filled Hospita 29a. Certifier 110 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai To the Vithin 2 29b. Signatury and title of Carliffer 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

JUN 0 5 2000

31. Date filed (Month, Day, Year)

William Covell

817 N. Broad St.

32. Registrar's Signature

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

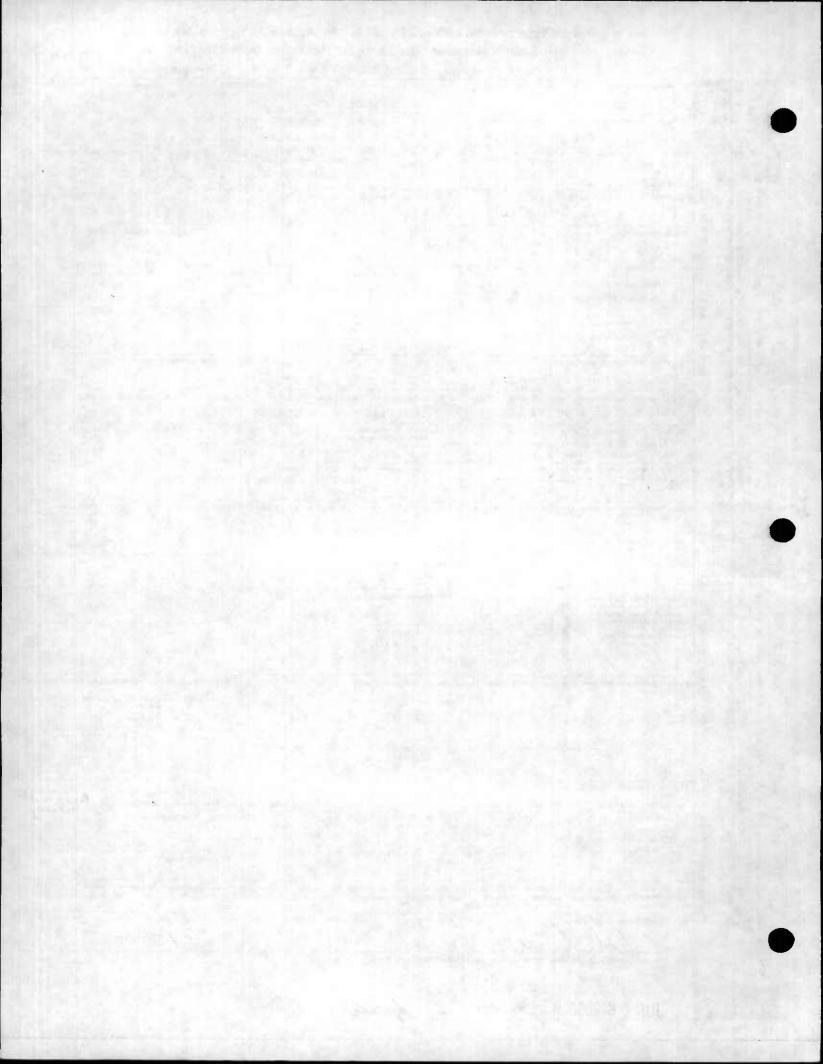
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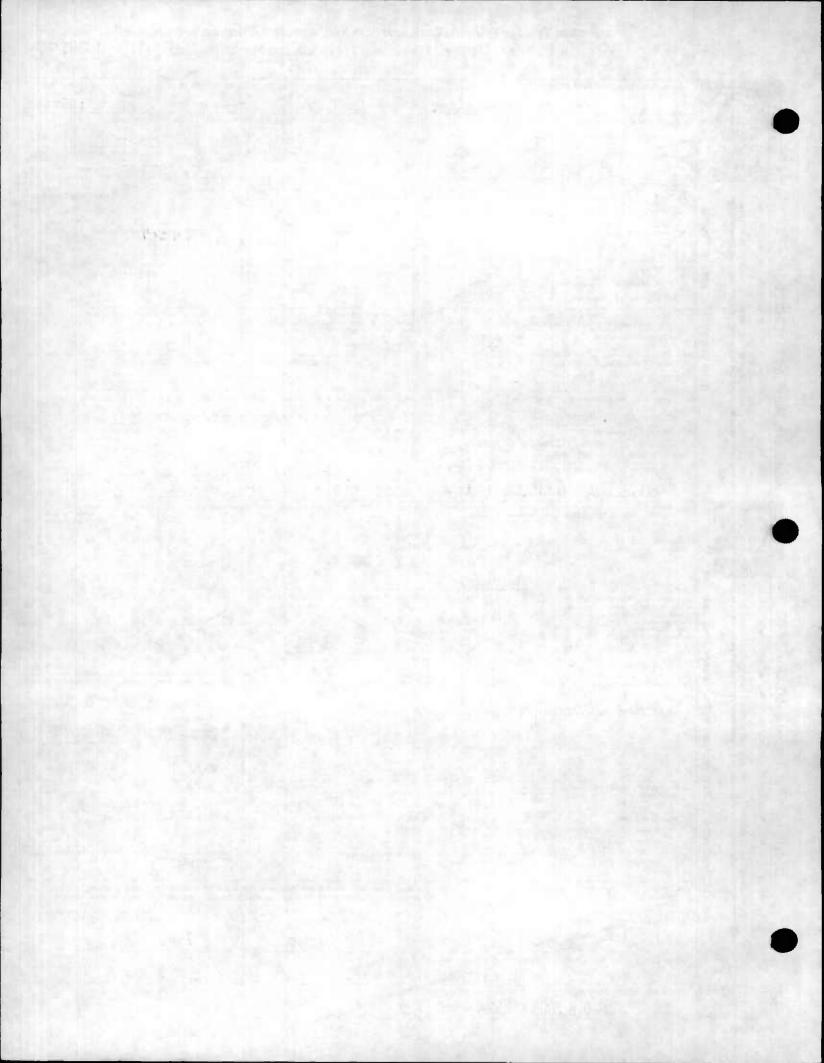
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State of Maryland / Department of Health and Mental Hygiene 00 19038

			Cen	tificate of	Death	Re	g. No.		
	1. Decedent's Name (First, Middle, Last,	)	N			2. Date of Death		(ear	3. Time of Deat
Physician / /Medical	Frank L.	loyd Haynes Jr				June		00	9:45am
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or Lo	ocation of Death	4c. County of	Deeth	
	Howard County Gene		18		Columbia		How	ard	
Funeral Director	5. Social Security Number 6. Sec. 418-16-1327	7. Age (In yrs. Id M 2□ F 79	ast birthday) Yrs.	Months Days		8. Date of Birth (Month, Day, July 29	Year)	Count	
B-1	10a. State 10b. County	10c. City	, Town or Loc	cation				10	d. Inside City Lin
or thems 23a or 28a-f sho miner must be notified at Funeral Director	MD Howard	1 E	Columb	i.a 101. Zip Code		146	og. Citizen of Wh	at Court	1 ☐ Yes 2 ☐
23e or sunt be n	5109 Durham Road E			21044		V4-7-	Unite	d St	ates
E 1	11. Marital Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: KOrea	If	Was Decedent of I I Yes, specify Cub I ☐ Yes 2 ☑ No	Hispanto Origin? (Sp pan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black,	White, e	
yolena. Ne than "natur it, the Medical Completed	15. Decedent's Edu (Specify only highest grad	ication	16a. Decede	lent's Usual Occup	pation	ina 1	6b. Kind of Busi	ness/Ind	ustry
than the Mee	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work ad)				
Hygien ther th mr. the		5+	Pro	fessor			Educa		
Mantal Hy irrised offs affic event	17. Father's Neme (First, Middle, Last) Frank Lloyd Haynes	s Sr.			18. Mother's Nam Pearl Sa	1	laiden Sumame;	)	No.
DEE	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing	g Address (Stree	t and Number or Rur	al Route Number,	City or Town, S	tate, Zip	Code)
E 22 P	Kathleen G. Haynes	s/Wife	5109 I	Durham F	Road East	Columbia	, MD 21	044	
T 5 5	20a. Method of Disposition	Co	ace of Dispos	sition (Name of natory or other pla	200)	Date 2	Oc. Location - C	ity or To	wn, State
ny or o	12 Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	demovel from State		Memorial		-8-2000	Clarksv	ille	, MD
	21. Signature of Funerel Service Licens	AAR TO							
Departs Imports any injudice	Sa a les	20 - 1-01	Hai	rry H. W	ess of Facility litzke's F	amily Fu	neral Ho	ome,	Inc.
	our n or	an comp			columbia P			ty,	MD 21043 Approximete
	23a. Pert1. Enter the disease, or compl shock, or heert feilure. List only or	ne cause on each line.	. Do not ente	ar the mode of dy	ing, such as cardiec	or respiratory arre	ist,	1	tntervel Between Onset end Deeth
hysician		A 40	1.1					1	1.
Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	a. ILES printers	portun	w		11/2		1	WG
	resulting in dealtry	Due to (or	es a consequ	uence of):				1	
in a		premis							WKS
tran	Sequentially list conditions,	Due to (or	r as e consequ	uence of):					
ing physician a e as the burial- Medical Ex	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	c. Ampli en	Lorohary	vota -					14/6
ing physician and e as the bunal-transit Medical Examiner	that initiated events resulting in death) Last	Due to (or	es a consequ	uence :	1-94	T 0.5			
or use									
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by the ett ached fo hysici	Part II. Other significant conditions con		ilting in the un	nderlying cause gi	iven in Pert I.				the causs of de
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s been signed by the ettend 2 should be detached for us Dieted by Physician	Part II. Other eignificant conditions con  Isulumi (AM) who		ilting in the un	nderlying cause g	iven in Pert I.		autopsy	3 ☐ Prot	- N
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use as the burial-transit permit. Pages 1, 2, 3 should

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for	be ned within 72 hours aret dean with the State Dept. of regain and wental hybere prior to burket, cremators, or removal.  IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF	MARYLAND / CE	DEPAR	TMENT	OF H	EALTH DEAT	AND I		YGIEN EG. NO.	E		. 2 0 0 2
	1. DECEDENT'S NAME (First, Middle, Last)							_	2, DATE OF I				3. TIME OF DEATH
	Knud Jensen HELS	TNG							MONTH	DA		YEAR	
									May 31		000		10:45 p. M
	4. SOCIAL SECURITY NUMBER 297-09-9308	5. SEX	6. AGE (In yrs. lest	birthday)	IF UNDER	DAYS	HOURS	24 HRS. MIN,	7. DATE OF E (Month, Da May 1	y. Year)	12	8. BIRTH Countr	
	9s. FACILITY NAME (If not institution, give st	reet and number)			9h CITY	TOWN O	R LOCATIO	N OF OF		,		INTY OF D	
OR	16505 Virginia Av		1		1/100		iamsı.				A.C. (2.5 c		ington
5	RESIDENCE OF DECEDENT												
DIRECTOR	Maryland Was	hington		10c. CIT	Y, TOWN O		юм 11iar	nspo	rt				10d. INSIDE CITY LIMITS? 1 YES 2 NO
	10e. STREET AND NUMBER					_	ZIP CODE				40- 017	1751 05 1	WHAT COUNTRY?
FUNERAL	16505 Virginia Av	enue, C5	1			101	. EIF CODE	217	95		iog. cit	IZEN OF T	USA
5	11. MARITAL STATUS		NT EVER IN U.S. ARI		13.	WAS DEC	ENDENT OF	F HISPAN	IIC ORIGIN? (S	pecify Yes	or No-	14. RACE	- American Indian,
B	1 Never Merried 2 🔀 Merried 3 Widowed 4 Divorced		1 ☐ YES 2 ☒ N WAR OR OATES	10		f yes, spe			n, Puerto Ricar			Speci	t, Whits, stc.
	15. DECEOENT'S EDUC	CATION	18s. OE	CEOENT'S	USUAL O	CCUPATIO	ON:		16b. KIN	D OF BUS	INESS/IN	DUSTRY	
E 1	(Specify only highest grade Elementary/Secondary (0-12)		life	ve kind of Do NOT u	work done ( se retired.)	during mo	st of working	7					
COMPLETED	1.2	College (1-4 or 5		idem	iolog	rist				nosp	ita1		
Σ	17. FATHER'S NAME (First, Middle, Last)	0	1 -1			,							
8									ME (First, Middl				
BE	Oswald Helsing						E	Anna	Chris	tens	en		
5	198. INFORMANT'S NAME (Type/Print) Miriam F. Helsing	- wife							Poute Number ( Willia				21795
- 3	20s. METHOD OF DISPOSITION		20b. PLACE A						OATE			City or To	
	1 Burisi 2 December 3 Rem	oval from State	cametery, crei						6/1/00			-	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENGLE -	паде	ISLO									,Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	M	inne	4			. Wil		*11				L HOME Md.21740
	23. PART I. Enter the diseases, or o	complications th	at caused the de	eth Do	not enter	the mo	de of dule	00 0110	h a a cardia o	0. 5000	reton, or	ma et	I Assessimate
	shock, or heert fellure.	List only one cs	use on each line		not enter	the mo	de oi dyli	ng, suci	n as cardiac	or realpi	ratory ar	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (Finsi	1	1 1			,	NA.						Onset and Death
	disease or condition resulting in death)	. Mer	rastati	10	Dro	340	te .	Con	a				
	, ,	DUE TO	OR AS A CONSEC	UENCE O	F):								
-													-
CERTIFICATION	Sequentielly list conditions,	b. OUE TO	O (OR AS A CONSEC	DUENCE O	n:								
F	If any, leading to immediate cause. Enter UNDERLYING		(****		. ,.								
5	CAUSE (Diseese or Injury	C	100 to 1 0011050										
ËΙ	that initiated eventa reaulting in death) LAST	002 10	OR AS A CONSEC	DUENCE O	+}:								
1	Total (III) CAST	d											
-	DARW II CAbou also Micros A a control	CO. C. H. H											
A	PART II. Other significant condition	e contributing to	deeth but not r	eaulting	in the ur	iderlying	g ceuee g	iven in	Pert I. 24s	PERFOR	AUTOPSY MED?	24b	. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
용									1	YES 2	DI-NO		COMPLETION OF CAUSE OF DEATH?
<u>u</u>												ŀ	1 TES 2 NO
2	DID TOBACCO USE CONT	PIRLITE TO C	ALISE OF DEA	TH Y	ES 🗍	NO E	LINC	ERTAI					1 123 1 10
A	25. WAS CASE REFERRED TO MEDICAL	KIDOTE TO CA			TH (Check		1 0110		, 0				
$\overline{0}$	EXAMINER?	HOSPITAL:	20.70	2 01 027	OTHER	3.							
YS.	1 TYES 240 NO	1 Inpatient 2	☐ ER/Outpetlant 3	□ DOA	4 🗆 Nur	sing Hom	o SEAR	sidence	8 Other (Sp	ecify)			
PHYSICIAN: MEDICAL	27. MANNER OF OEATH	28e. DATE O	F INJURY Day, Year)	28b. TIN	IE OF JURY	28c. INJ	URY AT		28d. OESCRI	BE HOW I	NJURY OC	CCURED	
	1 Natural 5 Pending	(Month),	say, roury		M		YES 2	NO					
В	a - a total	28e. PLACE	OF INJURY — At ho	me, farm,	street, fact	ory, offic			281. LOCATIO	N (Street	and Numbe	er or Bural I	Pouts Number
	4 Homicide determined	building	, stc. (Specify)						City or To	wn, State)			10010 11001,
<u> </u>													
7	29e. CERTIFIER (Check only	CIAN: To the best of	of my knowledge, de	ath occur	red at the t	lme, date	and place,	and due	to the cause(s	) and mei	ner ss ata	sted.	
COMPLETED	000)												e) end menner es atated.
	29b. SIGNATURE AND TITLE OF CERTIFIE	Λ											
H	A SIGNATURE AND TIME OF CERTIFIE	No.					29c. LICE			4	29d. DA		(Month, Day, Year)
2	Notice	NA CONTRACTOR OF THE PARTY OF T					DO	000	1694	J		6/1	1/00
F	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAL	ISE OF DEATH STEE	M 073 /T-	D-(-1) A								

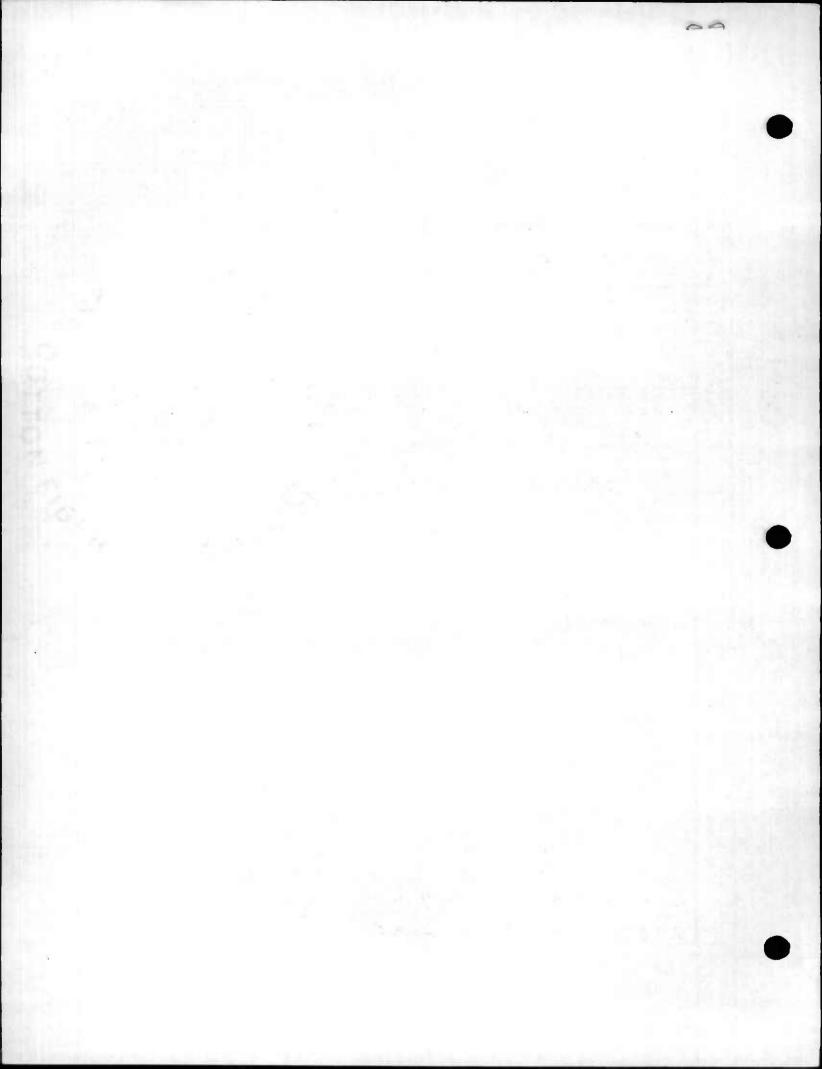
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

W. E. KUTZORA MO 747 Jorden

31. DATE FILED (Month, Day, Year)

JUN 0 2 2000 De 32. REGISTRAR'S SIGNATURE

JUN 0 2 2000



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month **Physician** 3 Eleanor Louise Hershberger 0113 June 2000 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Washington County Hospital If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dev. Year) **Funeral** Months Deys 1 M 2 F 74 213-22-2790 10,1925 Maryland Director Usuel Residence of Decedent death with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits ahow Md. Washington Smithsburg 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ U.S.A. 11302 Crystal Falls Dr. P.O. Box 272 21783 238 Funeral Herra : 12. Was Decedent Ever in U,S. Armed Forces? Raca - American Indien, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 0 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: White 3 Widowed 4 Divorced 'netural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nurse 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Peges 1 and 2 should be nent of Health end Mentel la marked Mamie Rinker Unknown 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21783 19e. Informant's Name/Reletionship (Type, Print) Department of Health e important: If itam 27 is any injury or other train Raymond H. Hershberger (Husband) 11302 Crystal Falls Dr. P.O. Box 272 Smithsburg, Md. 20b. Placa of Disposition (Neme of cametery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition June 6 Buria 2 Cremation 3 Removel from 8 Smithsburg Cemetery 2000 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Md. 22. Neme end Address of Facility 21. Signature of Funerel Service Licente Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783 ent1. Enter the disease, or complications that caused the death, shock, or heart feilure. List only one cause on each line. Do not enter the mode of dying, such es cardiac or respiretory errest, **Physician** rivicaisai Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examine The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of) physician the burial Box 68760. Due to (or es a consequence of) 89 use 23b. Did tobacco use contribute to the cause of death? Pert Ii. Other ajgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause death? Completed 2 INO 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to me examiner? Medical Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 Hospital 1 Impatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 ER/Outpatient 3 DOA his 27. Menner of Death 1 Givatural 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attanding s after dea. 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled 1 Cordiying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 2000 31. Dele filed (Month, De State

**DHMH 16 Rev 6/95** 

Registrar

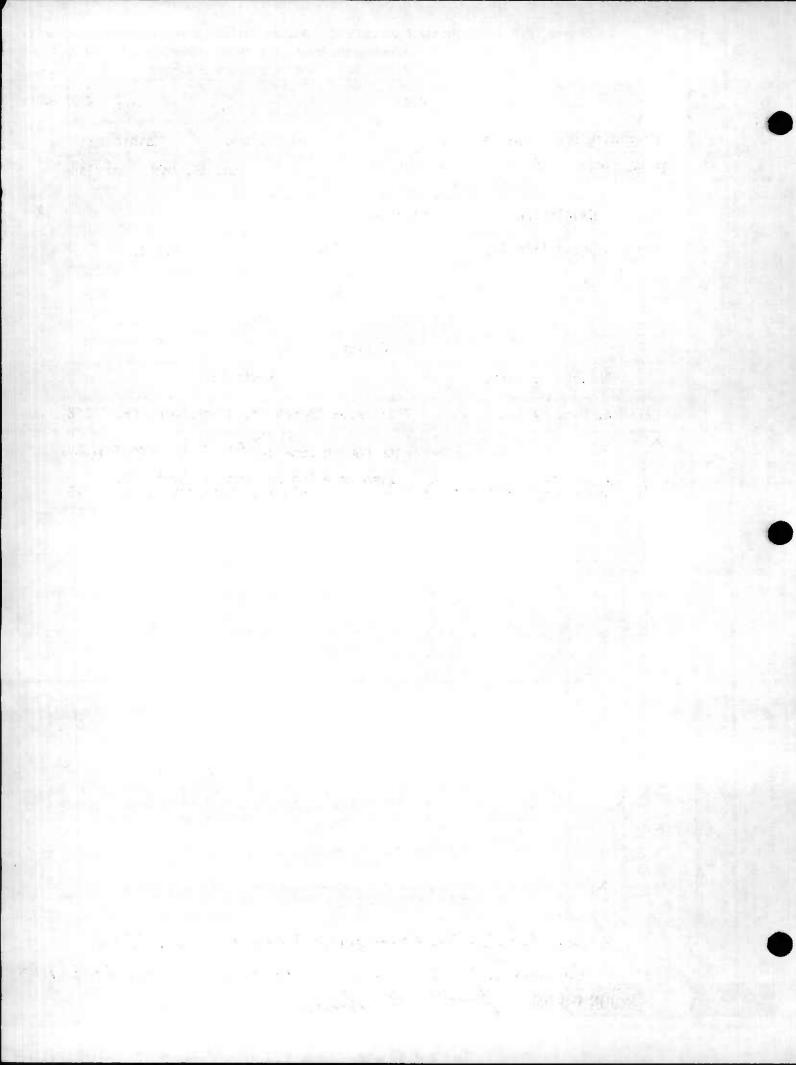
Hershberge

Date Rose Hay David 

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					C	ertifica	ite of	Death		Reg. No.	0 1	901	41
	Physic	ian	1. Decedent's Nema (First, Middla, Las		.,				2. Data of De		Yaar		ol Death
	/Medi			Adin	Hors	t			June	3	2000	4:00	A.M.
	Exami	ner	4a. Facility Nama (If not institution, giva					4b. City, Town, or	Location of Daat	h 4c. Cou	unty of Death		
L			Mennonite Old F			Millor	las 4 Vaas	Hagers		Wa	shing		
	Funeral Director		5. Sociel Security Number 6. Sec. 215-36-6755	7. Age (In y	rs. last birthd	Month	er 1 Yeer s Days	If Undar 24 Hrs Hours Min		iy, Year) 1909	Cou	place (Statintry) y land	ta or Foraigr
	yland		10a. Stata 10b. County	10c.	City, Town o	r Location						10d. insida	City Limits
	Mer	ţ	MD. Washing	ton	Hager	s town					1	1 □ Y	es 2 No
	th with the 23a or 28	Funeral Director	10e. Street and Number 13436 Maugansvi	lle Rd.			ip Coda 21740	)		10g. Citizen	of What Cou	ntry?	
21215-0020	n 72 hours after death with the Meryland "netural", or itams 23a or 28a-f ahow scitcel Examiner must be notified at	by	11. Marital Status  1 Navar Married 2 Married 3 Widowed 4 Divorcad	12. Was Dacedant Evar In Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva Yaar or Datas:	U,S.		edant of Hecify Cube	lispanic Origin? (S en, Maxican, Puar Specify:	Specify Yes or No to Rican, etc.)	i	Race - Ameri Black, White, ecify: Whi	, atc.	
5	hin 72 ho e. In "natur Medical	eted	15. Decedant's Edi (Specify only highast grad	ucation da completed)	16e. De	ecedant's Us	ual Occup	ation during most of wo	rkina	16b. Kind o	f Businass/ir	idustry	
121	c •	Completed	Elementery/Secondary (0-12)	Coilaga (1-4or 5+)	— \iii			during most of wo	· · · · · · · · · · · · · · · · · · ·	Agr	icultu	ire	
2	77 70 1-		8 17. Fathar's Nama (First, Middla, Last)			Farm	er	10 Matheda Ne	me (First, Middle				
Maryland	2 5 5 5	Be C	Abraham G	Horst					sie Baer		rama)		
2	d 2 should b th and Mente 7 is marked traumatic a	To	19a, Informant's Name/Ralationship (T		19h M	eiling Addre	se /Straat	and Number or R			um Stata 7i	n Codel	
<u> </u>	d2 sh ar		Laban A. Horst					Church Ro					
re,	f Health if Health of tem 27 is other tre		20a. Mathod of Disposition	200	Place of Di	enneition /A	eme of	T	Data		on - City or To		
Baltimore,	t. Pege fument c tant: If		1 Surial 2 Cremation 3 II 4 Donetion 5 Other (Specify)	) M	ennon	ite Ch	urch	Miller's Cemetery	6/6/00	Leite	rsburg	, Md	•
Ba	Depar Impor any ir		21. Signeture of Funaral Service Licens  H. Martin 2	imer-	2.	Zimme	rman	ss of Facility And Son lisle St.	Funeral Greenc	Home astle.	Inc. Pa. 1	7225	
x 68760,	eath certificate be executed  stending physician and ifor use as the burial-transit	Medical Examiner	Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated evants resulting in death) Last	b. — Dua to	(or as a con	sequance o	):	y Dis					
ã	th ce tendi	lan	_	d							1		
o O	the death by the etter	Physician	Part II. Other significant conditions co	ntributing to death but not r	asuiting in th	a underlying	causa giv	en in Part I.	23b. Dld	tobacco usa	contribute t	o the caus	e of death
က် ၂	that led b	by Phy							10	Yes 200 N	o 3 Pro	bably 4	Unknow
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	E # 8								1 🗆	Yas 2 N	5 1	☐ Yes 2	□ No
VIta	ysician: The s certificate director, pag	Be	25. Wes casa rafarrad to medical exeminar?	Hospitel:			Oth		ath (Check only	ona)			
0	Phys this ral di	. To	1 Yas 200 No	1 ☐ Inpatient 2  28a. Deta of Injury	☐ ER/Outpe			4 July Nursing F	loma 5 ☐ Rasi			(y)	
	After fune	tion	1 Naturel 5 ☐ Panding	(Month, Day Year)	28b. Tim Inju		28c. Injur Wor	k? Yes 2 □ No	28d. Dascribe	now injury oc	Corraci		
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			1964 Bud	hanon Tr	٤. 5	hade	16-00	w Pa	17256	Lo	uisc	oda	mr
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** 01, June LUCY MAE JOYCE JACKSON 2000 6:40AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner LaPlata Genesis Elder Care **IaPlata** Charles 5. Social Security Number If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) JAN. 17, 1907 Birthplace (State or Foreign Country)
 VIRGINIA 7. Age (In yrs. last birthday) **Funeral** 1□ M 2\ F Days Yes 236-32-2054 93 Director Usual Residence of Decedent with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow rithan "natural", or items 23s or 28s-f ahor the Medical Examinar must be notified at 1 Yas 2 No Director MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6120 BIVINS PLACE / P.O. BOX 703 20646 UNITED STATES deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 | Yas 2 D No If Yes, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d. Department of Health and Mental Hyglene. Important: if New 27 le marked other than "naturaf", or han all plury or other traumatic event, the Medical Examinations. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 20 No Specify: Specify: BLACK é 3X Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6TH GRADE NURSE ASSISTANT MEDICAL/GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maiden Sumama) MARY CLARK JOYCE SAMUEL JOYCE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 1209 PALMER ROAD #2, FORT WASHINGTON, MARYLAND 20744 BARBARA VAUGHAN / DAUGHTER 20b. Place of Disposition (Name of cometery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from Stata HARMONY MEMORIAL PARK 6/7 /00 HYATTSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signifiance of Funeral Service Licensee

THORNTON FUNERAL HOME, P.A.

1. 201A C. THORNTON JOHNSON M00583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

Approximate

Approximate

Approximate

Approximate

Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Cause (Finel disease or condition resulting in death) /Medical CONGESTIVE HEART FAILURE Examiner Physician/Medical Examiner physician and the burlai-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSLON Records, à CEREBROVASCULAR ACCIDEN 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy NEPHROPATH 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours after deeth.
 Funeral Director: After this certifical 25. Was casa referred to medical axaminer?
1 ☐ Yas 2 🛪 No 8 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) á To the Hospital or A within 24 hours after To the Funeral Direct completaly filled in by 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, data end place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one)

State Registrar

31. Data filed (Month, Day, Year) 32. Registger's Signature JUN 0 6 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and titla of certifier

Vidyasagar Anmangandla, M.D.

Rt. 5 & Golden Beach Rd. P.O. Box 282 Charlotte Hall, MD 20622 Jacks

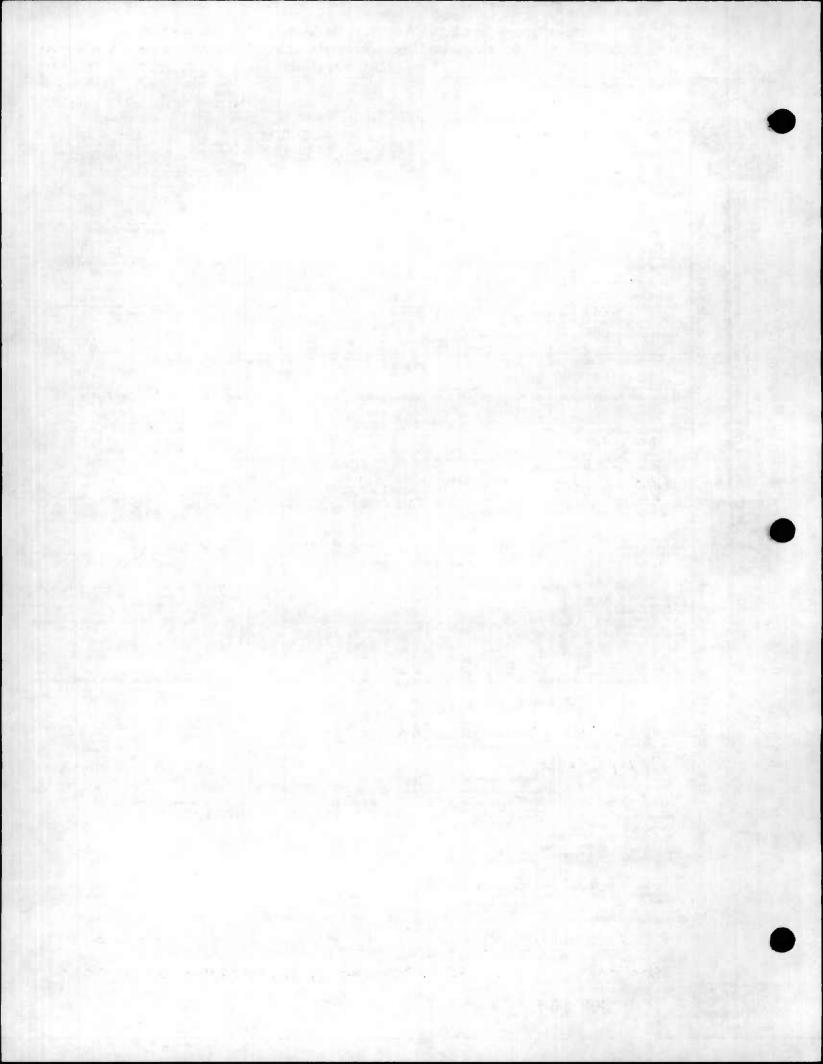
29c. License number

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29d. Data signed (Month, Day, Year)

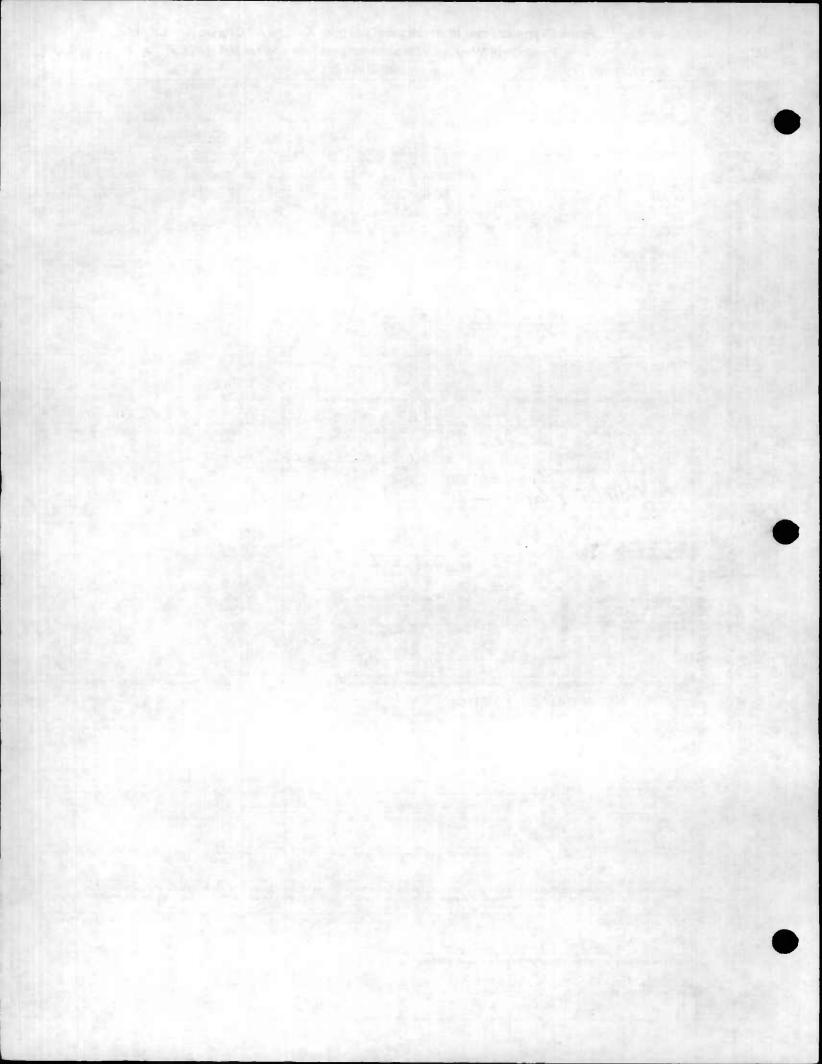
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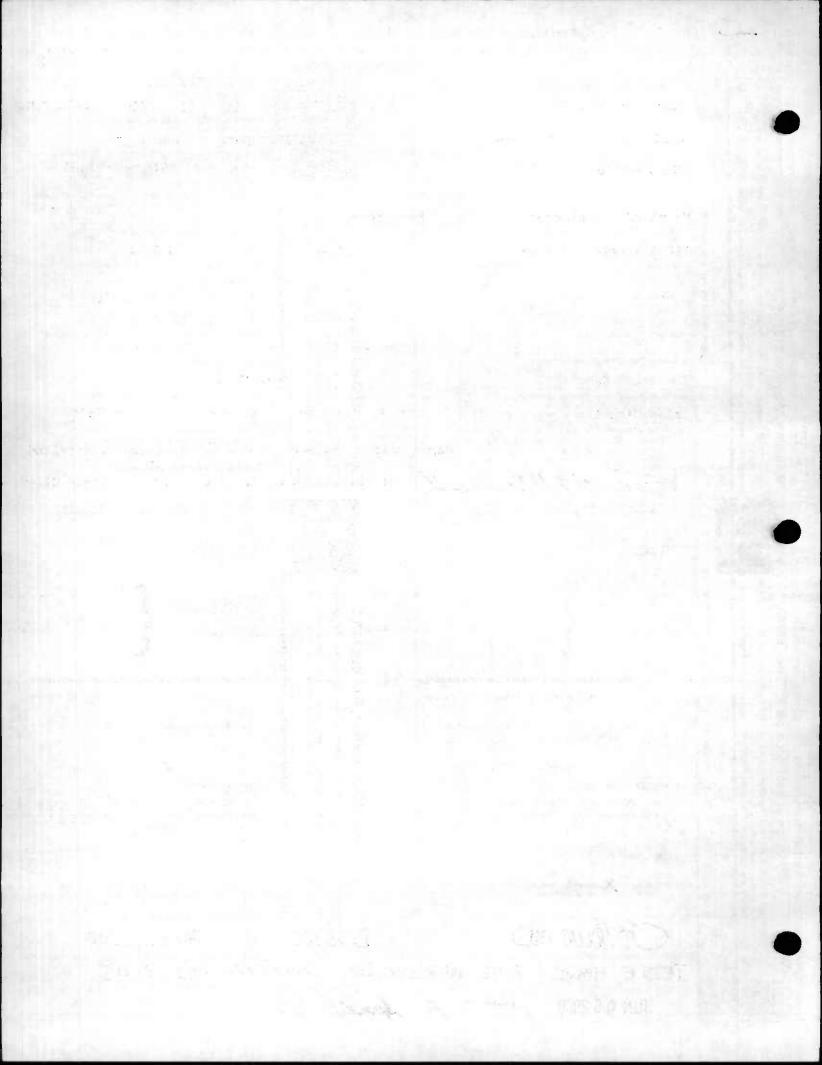
DHMH 16 Rev 6/95



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

									Certifica	ite of	Death			Reg. No.	U	1 70 44
				1. Decedant's Nama (First, Midd	la, Last)								2. Data of D	eeth	CALL OF	3. Tima of Death
		Physic /Medi		Ruth Louise LA	NDIS	3							Month May	21 2	Yaar 000	11:32 P.M
	3	Exami		4a. Fecility Nama (If not institution		-	ım <i>ber)</i>				4b. City, To	wn, or Lo	cation of Daa	77	y of Death	
				Williamsport N	lursi	ing Ho	me				W:11	liams	port	Wash	ingto	on.
		Funeral		5. Sociel Sacurity Number	6. Sex		7. Aga (In yr	s. last birth		ar 1 Yaer	If Undar	24 Hrs.	8. Data of Bi	irth ,		piaca (Stata or Foreign
		Director	ш	220-26-5376	10	M 21₹F	8	34 Yr	s. Months	Days	Hours	Min.	March	ay, Year) 11 1916	Ma	ryland
		D.		Usual Rasidance of Decedant												
		show thow		10a. Stata 10b. County	1		10c. (	City, Town o	or Location							10d. Inside City Limits
		a M	5	Maryland Wash	ingt	on		Ha	gersto	wn						1 ☐ Yes 2/☐ No
		if the second	Directo	10e. Street and Number					10f. Z	ip Coda			ļ	10g. Citizan of	What Cou	intry?
		23a		17806 Virginia	Ave	nue				217	40			U.S.	Α.	
		after death with the Menylan or Herns 23e or 28e-f show eniner must be notified at	Funeral	11. Marital Status	1	12. Wes Dec	edant Ever in orcas?	U,S.	13. Was Dec If Yas, sp	edant of F	lispenic Origan, Maxican	gin? (Spa	cify Yes or N	0- 14. Ra	ce - Ameri	ican indian,
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	Mai			19a. Informant's Name/Raiations										ber, City or Town		
3		F W 44 F		Trina Mickells	-Da	ughter			01 E.		a Mon	tanas		son, Ari		
2	Baltimore,			20e. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation	3 □R	amoval from	Stata	cematary,	isposition (Na cramatory or	othar pla		i Ie	Data	20c. Location		
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		certificate be executed ding physician and use as the burial-transit	Examine	Sequentielly list conditions.	<b>1</b> b	,	Dua to	(or es a cor	nsequence of	):						
0	Ó	an a		Sequentielly list conditions, if any, leading to immediata cause. Entar Underlying Cause (Diseasa or Injury					·	•						
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_	XOX				d.										1	
7	. B	thet the death ed by the atter detached for o	SICI	Part II. Other significant condition	one cont	ributing to d	eath but not ra	asulting in th	na undartying	cause giv	ren in Part I.		23b. Did	tobacco use co	ontribute f	to the cause of death?
MAY	0.0	by the	بر ک										10	Yee 2 No	3 Pro	bebly 4 Unknown
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	00	s be	olet	SEMILE DEMI	ENT	H							pen	ormed?	CC	omplation of cause
ANDIS	R	The le	mc										10	Yas 2 No		
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3	Division of Vital Record	Physician: The lew this certificate has I ral director, page 2 s	To Be	examinar? 1 ☐ Yes 2X No	-	ospital:	Inpaliant 2		-N1 0 D	Oth			(Check only			
	of	ding Phys h. After this funeral di		27. Mannar of Death		28a. Data		28b. Tim						how injury occu		19/)
RUTH	on	Afte fund	ţ	1 Naturai 5 Pandir 2 Accidant Invasti		(Mon	th, Day Year)	Inju	iry M	28c. Injur Wor	k? Yas 2 □!			,.,.,		
2	S	deal deal ctor: y the	fica	3 ☐ Suicida 6 ☐ Couid	not be	28a Place	of Injury - At	homa farm					8f. Location	Street and Num	ber or Rur	ral Routa Number.
	Ö	after Dire	Certification:	4 ☐ Homicida datam	IIIIeu	build	ing, etc. (Spec	city)	,,	.,,				wn, Stata)		
		spita sours seral		29a. Cartifier 12 Certifyin	a Physi	clan: To the	best of my kr	nowledge, d	aath occurred	d at the tin	na data an	d place a	nd due to the	causa(s) and m	annar as	stated
		To the Hospital or Attending Phy within Ea hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check only 2 Medical one)	Examin	er: On tha b	asis of axamir nar stated.	nation and/o	or Invastigatio	n, in my o	pinion, daat	th occurre	d at tha tima,	data and place,	and dua t	o tha causa(s)
		of this of the office of the o	Me	29b. Signature and title of partifie	r	The state of the s			29	9c. Licens	a number			29d. Dala signe	ed (Month.	Day, Year)
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				30 Name and address of	e - 1		an ad alcosts dis-	02-1 /~	ma Delian	) > 5	100			22 Amin	, 20	00
				30. Nama and addrass of person		7 C	or or death (Ite	an 238) (1y	pe, Print)		RAN	12	020.	MP -	21713	>
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State of Maryland / Department of Health and Mental Hygiene

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MAUDE LONG		Certific	cate of Death	Reg. No.	00 19045
Physician	Decedent's Name (First, Middle, Las			2. Dete of Death Month Day	3. Time of Deeth
/Medical	MAUDE	LONG	th City Town and	MAY 28, 20	
Examiner	4a Facility Name (If not Institution, give MARYLAND GENERA		4b. City, Town, or L BALT IMO	DE O	Himore
Funeral Director	190-17-1107		Inder 1 Yeer If Under 24 Hrs. oths Days Hours Min.	8. Date of Birth (Month, Day, Year) 09-07-34	Birthplace (State or Foreign Country)
e Menyland la-f show unsd	Usual Residence of Decedent  10a. State  MD  BAI  Time Decedent	MORE BAILING			10d. Inside City Limits 1 Mayes 2 □ No
other death with the Mei writems 23s or 28s-f s other must be notified Funeral Director	100 PEnnsylvania	Are. Apt. 910	1. Zip Code 21202	U	What Country?
7 0 0	3 ☐ Widowed 4 ☐ Divorced	1 Tyes 25 No	Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puertoes 2 A No Specify:	pecify Yes or No- b Rican, etc.) 14. Ri Bl	ece - Americen Indian, lack, White, atc.
72 ho	15. Decedent's Ed (Specify only highest grad	ucetion 16a. Decedent's (Give kind c	Usual Occupation of work done during most of work OT use retired)	king 16b. Kind of	Business/Industry
C BEST C	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	estic	PR:vate	
Maryland d2 should be filt th and Mental Hy 7 is marked oth trsumatic event	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maiden Sums	ame)
should the market market	19e. Informent's Neme/Relationship (7	ivne Print) 19h Mailing Adv	dress (Street end Number or Ru		m State Zin Code)
Mar. end 2 sho	MARY A. Long -				21801
ges 1 and tof Health if Itam 27 or other tr	20a. Method of Disposition	20b. Place of Disposition	(Name of		n - City or Town, Stete
Pages Pages nent of limit: If the	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State		4-3-00 Pocon	roke, MD
Baltimore, pemit. Pages 1 e Dependent of Hee Important: if item any injury or othe	21. Signature of Funeral Service Licens	see 22. Nam	hanu E. Ward	Fundal Ham	
	23a. Part 1. Enter the disease, or comp	lications that caused the leath. Do not enter the one cause on each line.	mode of dying, such as cardiac	or respiratory errest,	Approximete Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Ortenos conotic		suun Dist	)) <sup>2</sup>
58760, icate be executed physician and stree bunal-transit		Due to (or as a consequence	of):		
5 06 2	resulting in death) Last	Due to (or as a consequence	of):		
Box death cert e attendin d for use	Part II. Other significant conditions co	ontributing to death but not resulting in the underly	ring cause given in Part I	23b. Did tobacco use o	contribute to the ceuse of death?
ds, P.O. Box (ires that the death certification is signed by the attending dip detached for use a dip by Physiclan/M.	Dinnes HE	4 TVS	ing cause given in ranti.	1 ☐ Yes 2 ☐ No	Marie Commercial Comme
Records, he law requires the law seen signe sge 2 should be				24a. Was an autopsy performed?	24b. Ware autopsy findings evailable prior to completion of cause
Vital Record Iden: The law requir certificate has been a rector, page 2 should				INSPECTION  1 Yes XX No	of death?
release The Secretificate director, pa	25. Wes case referred to medicel			ath (Check only one)	
	XX1es 2 No			lome 5 Residenca 8 □C	
Vision Attending Partending Pector: After by the funerial fill Cation:	27. Menner of Death  Control o	28a. Date of Injury (Month, Dey Year)  28b. Time of Injury  M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occ	urred
Division of standing P at a Director: After the timer death.  The standing P at the	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide detarmined	28e. Place of Injury - At home, farm, street, fa building, atc. (Specify)	ictory, office	28f. Location (Street end Nui City or Town, State)	mber or Rural Route Number,
Division o To the Hospital or Attending Ph within 24 hours after death. completely filled in by the funeral Medical Certification:		rician: To the best of my knowledge, death occurrence: On the basis of examination and/or invastige and manner steled.	rred at tha time, data and place ation, in my opinion, death occu	e, and dua to the cause(s) and arred at the time, dete and plac	manner as stated. e, and due to the cause(s)
To the comple	29b. Signature and title of certifier	A 14	29c. License number		ned (Month, Day, Year)
	> Mayno	meghile our	O.C.M.E	MAY	28, 2000
	30. Neme and address of person who o	completed cause of daeth (Item 23a) (Type, Print)	reet, Baltimor	e. Maryland 21	1201
State	31. Date filed (Month, Day, Year)	32. Registrar's Signatura			

DHMH 16 Rev 6/95

ORIGINAL

MATURE CONTROL CONTROL

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 4:40 AM Month DOCIA E. LUPTON 5 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Snow Hill Nursing & Rehabilitation Center WorcesTe & Snow Hill If Under 24 Hrs. 8. Dete of Birth (Month, Day, 5. Sociei Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months Deys 80 577-26-5665 February 17, 1920 Virginia Usuel Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Somerset Crisfield 1XYes 2□No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4 Village Drive - Apt. 25 21863 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American indien, Bleck, White, etc. 1 ☐ Yas 22 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 210 No Specify: Specify: White 3 ☐Widowad 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Grade 11 Homemaker At Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Wyatt G. Pruitt Mary Olevia Crockett 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Marguerite Luce (Sister) 4719 Poplar St. - Crisfield, MD 21817 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Ramovel from Steta Sunnyridge Memorial Park 5/24/00 Crisfield, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of miral Service Lice 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert Bradshaw, Jr. 306 W. Main St.- Crisfield, MD 21817 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one cause on each line. interioscleratie Cardiovasculas Discus Immediete Cause (Final disaese or condition resulting in deeth) Dua to (or es e consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings evellable prior to completion of cause of death? 24e. Wes an eutopsy performed? 1 ☐ Yas 2 🛪 No 1 ☐ Yes 2 1 No 25. Was case referred to medical 26. Placa of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10e. Stete

Director

Funerai

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Completed

Be

2

**Funeral** 

Director

permit. Pegas 1 and 2 should be filled within 72 hours after death with the Meryland Department of Haelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tra Medical Examinat must be retired en

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed

Be

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Medica

ettending physician end for usa as the burial-transit ed by the e this To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is

requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or Injury that initiated evants resulting in deeth) Lest

1 Yes 2 No

5 Pending Investigation

6 Could not be determined

27. Mannar of Deeth

1 Meturel

2 Accident 3 ☐ Sulcide

4 Homicide

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Yes 2 No

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 15 Certifying Physician: To the best of my knowledga, daath occurred et the tima, data and plece, end due to the ceusa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daeth occurred at the tima, dete end plece, and due to the causa(s) end manner stated. 29b. Signeture and title of certifier 29c. License number 29d. Deta signed (Month, Dey, Year)

30. Neme engleddress of person who completed ceuse of death (item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR.; SALISBURY, MD 2180)
31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

State Registrar

**DHMH 16 Ray 6/95** 

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THE THE WOLLD'S LOCAL STREET WAS A STREET OF THE STREET

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Richard C. McPeak, Sr. 0330 2000 JUNE 01 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Elkton Ceci1 If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Days Hours Min. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 15€M 2□ F Yrs. 215-40-0747 57 Director October 3, 1942 Maryland **Usual Residence of Decedent** the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Meryle Department of Heelth end Mentel Hyglene. Important if them 23e or 28e-1 ehow important if them 23e or 28e-1 ehow any fluxy or other treumite event, the Medical Exemples must be notified as Maryland Ceci1 1 ☐ Yes 2 ☐ No Director North East 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 332 Old Bay View Road 21901 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ◯ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking Truck Driver 1.0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Rufus C. McPeak Regina M. Brammer 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth A. McPeak (Wife) 332 Old Bay View Rd. North East, Md. 21901 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 3☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 6/5/00 West Chester, Pa. R.A. Ferris Inc. 22. Name end Address of Fecility Gee Funeral Home 21. Signature of Euro 259 E. Main St. Elkton, Md. 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart vailure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical ( Stopyloans LASA (+) Examiner Due to (or es a consequence of): Examiner Drawer meeles physician and s the burlat-transit Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Records, P.O. Box 68760, copp, D, Ewylsen.
Due to (or as a consequence of): Physician/Medical Remio Memoria 23b. Did tobacco use contribute to the cause of death? Part II. Other alignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by d be detact Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 20 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of Affac Natural 5 ☐ Pending or Attending after death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be 3 C Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lectory, office building, etc. (Specify) 4 [] Homicide To the Hospital of within 24 hours a To the Funeral D completely filled. Medical Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Vi

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year) Registrar

JUN 0 2 2000

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CHIH HSU MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



223

West main St. EHCtor hed 21711

29c. License number

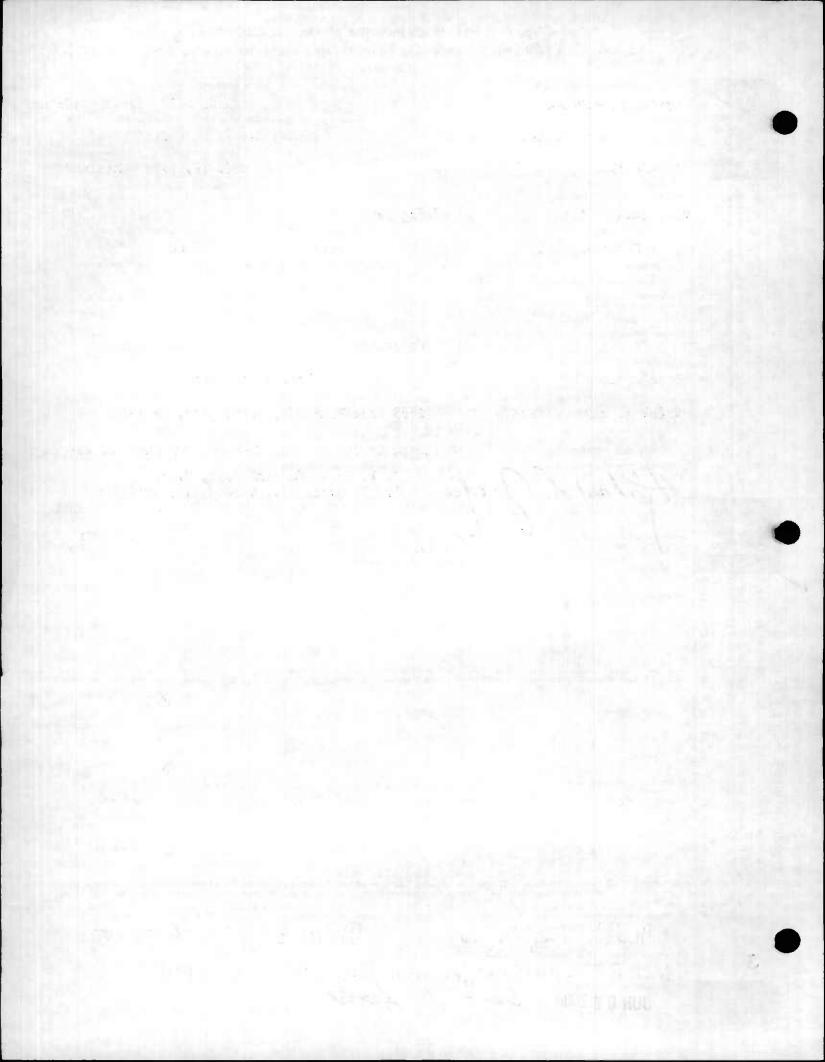
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29d. Date signed (Month, Day, Year)

6/1/00

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician (Medical Examiner)    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	9 9 E E 9		12/	111	-1:	K	. 7. 1	Foar	d Fune	ral f	Home,	P. A.		
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Due to (or as a consequence off):    Cause (Disease or injury that inhitated evenis resulting in deeth) Lest   Cause (or as a consequence off):	n end ial-tra	Exa	sequentially list conditions, if eny, leading to immediate		Due to (or	as e conse	quence or):							
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Per II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.    23b. Did tobacco use contribute to the cause of cause	ficet phy s th	8	resulting in deeth) Lest		Due to (or	as a consec	quence ot):							
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30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  No. 1 R Taylor Jr MD PO 459, Rising Sun, M8 21911  State  31. Dete filed (Month, Dey, Year)  32. Registrar's Signaturey	hysi his c			1 Linps		ER/Outpatier		A J	4 LA Nursin					)
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  No. 1 R Taylor Jr MD PO 459, Rising Sun, M8 21911  State  31. Dete filed (Month, Dey, Year)  32. Registrar's Signaturey	fter t	ë		28e. Dete of to (Month, i	njury De <i>y Year)</i>		f 28	Bc. Injun Worl	at c?	28d.	Describe h	ow injury occur	red	
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30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  No. 1 R Taylor Jr MD PO 459, Rising Sun, M8 21911  State  31. Dete filed (Month, Dey, Year)  32. Registrar's Signaturey	the the	D C	one)	end menner	stated.									
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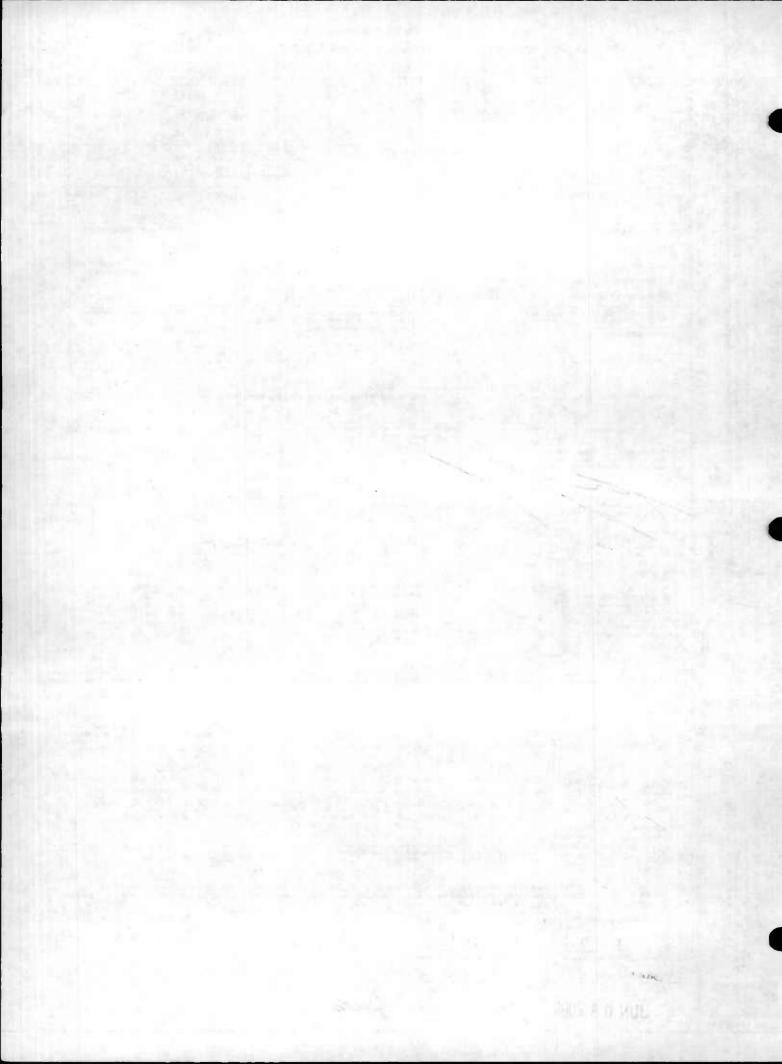


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State of Maryland / Department of Health and Mental Hygiene 19049

				y tarrer z	Certificate of		Re	g. No.	) (	50,1
		1. Decedent's Neme (First, Middle,	Last)				2. Dete of Deeth	1	Vana	3. Time of Death
	Physician /Medical	Mary E. Miller					June	Dey 4 2	Year 2000	9:00 pm
	Examiner	4e Facility Name (If not institution, g	give street end number)			4b. City, Town, or L		4c. County		
		Sunbridge Care	for Elkton			Elkton		Ceci	il	
	Funeral Director	215-24-3687	. Sex 7. Age (I	n yrs. last bin	thday) If Under 1 Year Months Deys		8. Date of Birth (Month, Day, April 2	Year) 0,1912	9. Birthp Cour Penn	place (Stete or Foreign stry) SYLVania
	pu *	Usuel Residence of Decedent  10a. State 10b. County	16	Oc. City, Town	n or Location				1	0d. fnside City Limits
	deryd f sho	Maryland Cec		Elkt					1.	1 X Yes 2 No
	rect noth	10e. Street and Number	ш	EXRL	10f. Zip Code		10	og. Citizen of V	What Cour	ntry?
	uter deeth with the Me rear 23a or 25a-1 s close must be noutle. Funeral Director	1 Price Dr.			2192	1		USA		,
,	ma 2	11. Meritel Stetus	12. Was Decedent Eve	r in U,S.	13. Was Decedent of If Yes, specify Cul	_	pecify Yes or No-	14. Rac		an Indien,
altimore, Maryland 21215-0020		1 Never Merried 2 Merried 3 X Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 💢 No If Yes, Give Yeer or Detes:		1 ☐ Yes 2 ☑ No		Hican, etc.)	Specify	white,	
2	72 ho	15. Decedent's (Specify only highest of	Education	16a.	Decedent's Usual Occu	pation	ring 1	6b. Kind of Bu		
7	uid be filed within 72 hours when by John than the different order than "natural"; or the seart, the Medical Example as a Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of work done life. DO NOT use retin	ed)	ung			
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Mai	h end h end is r reun	19a. Informent's Neme/Reletionship			. Meiling Address (Stree					
oʻ.	ロコペト	Walter A. Reyno. 20e. Method of Disposition			00 Woody Br			Oc. Location -		
و	0 0 - 2	1 XBurial 2 ☐ Cremetion 3	Hemover from State		Disposition (Name of y, cremetory or other plant					
	permit. Pag Department Important: I any Injury o	4 Donetion 5 Other (Spec		west N	ottingham C	emetery!	6-9-00	Colora,	Mar	yland
Ba	Depa Impo eny f	21. Signature of Funeral Service Lic	911500		R. T. Foa	rd Funera	l Home,	P. A.		
			4		1111 S. Qu	een St	Risina Si	un. MD	2191	
et i	-	23 Enter the disease, or co	mplications that caused the ly one cause on each line.	e death. Do r	not enter the mode of dy	ing, such es cardiac	or respiretory erre	st,	1	Approximete Intervel Between Onset and Death
	hysician /Medical	Immediate Cause (Finel	0		_1	01	0 1		1	Criser and Death
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ည္	nple								of	death?
= F	ysician: The law is certificate has I director, page 2 s						1 ☐ Ye	s 2000	1[	TYes 2□ No
	ector Be	25. Wes case referred to medical examiner?	Hamilal.				th (Check only one	)		
of Vital		1 Yes 2 No	Hospitel: 1 Inpatient	2□ER/Ou	tpatient 3LJ DOA		ome 5 Reside			y)
2	death. tor: After this of the funeral discretion: To	27. Menner of Deeth 1 ☑Netural 5 ☐ Pending	28e. Dete of Injury (Month, Dey Ye		njury M 1 [	ork? ]Yes 2 □ No	28d. Describe ho	w injury occurr	red	
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Division	all or Attending is after death.  It Director: After the funeral or in by the funeral Certification:	4 ☐ Homicide determine	bullding, etc. (5	Specify)	ini, street, rectory, onice		City or Town	Stete)	or or ridic	, riodio ridinosi,
_	Sours filler	29a. Certifier 1 Certifying F	Physician: To the best of m	v knowledoe	death occurred at the t	ime, date and place.	end due to the ca	use(s) end me	nner as s	tated.
3	within 24 hours after or to the Funeral Direct completely filled in EMedical Certi	(Check only 2 Medical Exu	aminer: On the basis of exc end menner steted	aminetion sno	d/or investigetion, in my	opinion, deeth occur	red et the time, de	te end plece,	end due to	the cause(s)
	within comp	29b. Signeture end title of certifier	0 . 0	1	29c. Licen	se number	29	d. Date signer	d (Month,	Day, Year)
		) (hr	Sahal	en	1000	26182	5 (	0.6	00	
	6	30. Neme and address of person wh								
	5	M. SACHDEV,	327 E.CE	CIL	AVE,	NORTH	EKSY	us	,	
	State	31. Dete filed (Month, Dey, Year)	32. Registrar's	Signeture	1	,				
	Registrar	JUN 0 6 2000	per	Ø.	sports					

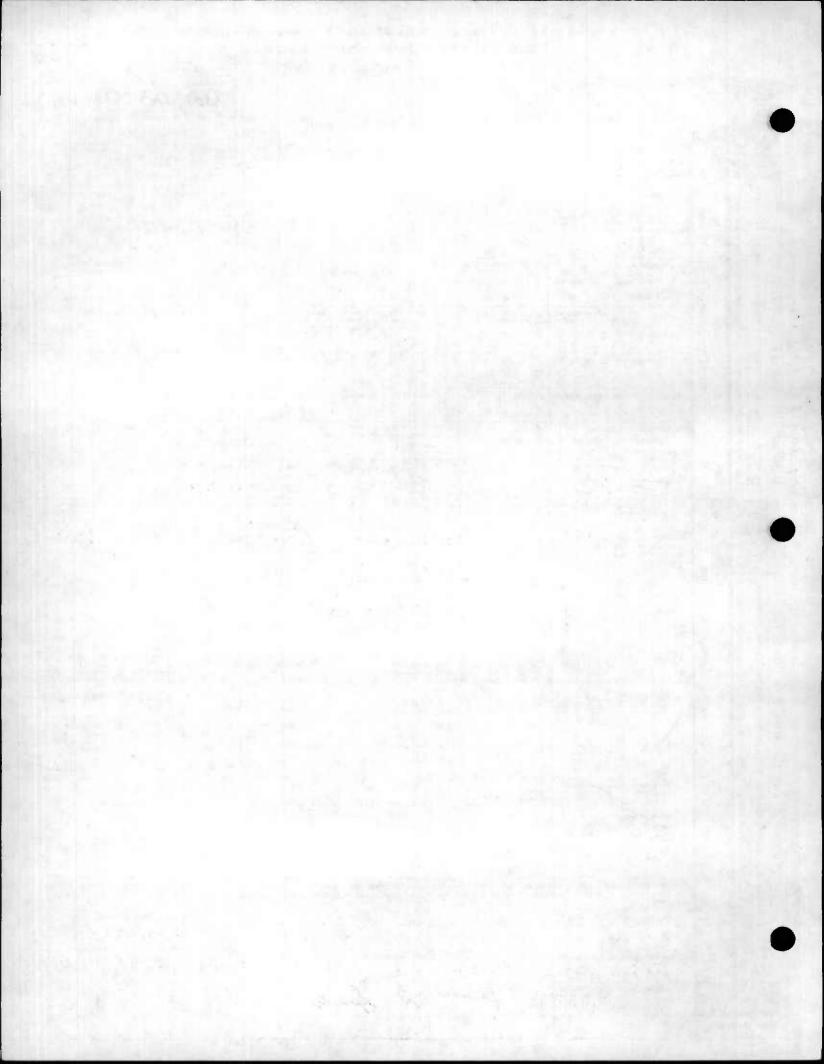
DHMH 16 Rev 6/95



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	110030	State of Mar	yland / Dep			Mental Hyg	jiene () (	19050
	1. Decedent'a Name (First, Middle, La	st)				2. Dete of Dea	th	3. Tima ol Deeth
Physician /Medical		ulia MERTZ				06	693	1510
Examiner	4a Fecility Name (If not institution, giv				4b. City, Town, or I		4c. County of	
	Washington Count  5. Social Security Number 6. S	-	to one to at high day	If Under 1 Yea	Hagerst			ington
Funeral Director		ex / / Age (	In yrs. last birthday 81 Yrs.	Months Day		8. Date of Birth (Month, Day Aug 1	Year) 4,1918	9. Birthplace (Stete or Foreign Country) Mary Land
Pu & m	10a. State 10b. County	1	0c. City, Town or L	ocation				10d Inside City Limits
) the Marylar 28e-f show notified at	Maryland Washingt	on	Hagerst	own				1⊠Yes 2□No
with the Marylan 3a or 28a-f show It be notified at	10e. Street and Number 222 Alexander St	reet		10f. Zip Code 217			U.S.A.	- 100
320 are after dead in after dead barminer mu	11. Marital Status  1 Never Married 2 Amarried  3 Widowed 4 Divorced	12. Was Decedent Events Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datea:	er in U,S. 13.	Wes Decedent of II Yes, specify Co	f Hispanic Origin? (S uban, Mexican, Puert lo Specify:	pecify Yea or No- o Rican, etc.)	14. Race Bleck Specify:	- American Indien, k, White, etc. white
215-99 Pin 72 hours Medical E	15. Decedent's Ec (Specify only highest gra	lucation de completed)	16a. Dece (Give life.	edent's Usual Occ e kind of work dor DO NOT use reti	cupation ne during most of wor ired)	king	16b. Kind of Bus	siness/Industry
212 213 213 213 213 213 30min	Elementary/Secondary (0-12) 0-6	College (1-4or 5+)	Co	ok			restau	ırant
Maryland 42 should be line 10 to market by 10 to market other 17 to market other 10 to Be O	17. Fether's Name (First, Middle, Last) Oscar M.	Smith, Sr.	·			ne <i>(First, Middle,</i> lie Stul		)
S S S S S S S S S S S S S S S S S S S	19a. Informant's Name/Relationship (			ing Address (Stre	et end Number or Ru	ırai Route Numbe	r, City or Town, S	Stete, Zip Code)
altimore, M mil. Pages 1 and 2 gestiment of Health y portent: If them 27 is y injury or other tra	Mrs. Rosalie M. R  20a. Method of Disposition  1 DXBurial 2 Cremation 3 C		1882 20b. Place of Disp cemetery, cre			Date		Maryland 21742 City or Town, Stete
2 El garante	4 Donation 5 Other (Specify		Rest Hav	en Ceme	tery	June 7,2000	Hagerst	own, Maryland
Ball Ball Depart Import	21. Signature of European Service Licen	M rese	1	2. Neme and Add		Minnich vd., Hag		Home Maryland 2174(
P.O. Box 68760, ast the death certificate be executed by the attending physician and obsched for use as the burla-transit Physician/Medical Examiner	23a. Part1. Enter the disease, or com shock, or heart lailure. List only Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ab	les pen ple corse	a very squence of): .  Manual	Deroit			Intervel Between Onset and Death
O. El deat he att sed for selcit	Part II. Other significant conditions of	ontributing to death but r	not resulting in the	underlying cause	given in Pert I.	23b. Did to	obacco use con	tribute to the cause ol death?
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BCOFC aw requires been as been a			m 12 z			24e. Wes a perfor	in autopsy med?	24b. Were eutopsy findings evailable prior to completion of cause of death?
ai Rei i Thei cate he						10 Y	es 2 DNO	1 Yes 2 We
of Vitai   Physician: Th this certificate ral director, pa	25. Was case referred to mindicut examiner?	Hospital:			Other	ath (Check only or		
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Division of To the Hospital or Attanding P within 42 hours after death. To the Funeral Director: After toompletsly filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc. (	- At home, lerm, st Specify)	treet, lectory, offic	28	28f. Location (S City or Tow		or or Rurel Route Number,
To the Hospital or To the Hospital or To the Funeral Direct completely Illed in Medical Cert	29a. Certifier 1 Certifying Ph	ysician: To the best of n liner: On the basis of ex and manner stete	amination and/or in	th occurred at the nvestigation, in my	time, dete end plece y opinion, deeth occu	, end due to the corred et the time, c	ause(s) and mer late end plece, a	nner as stated. nd due to the cause(s)
To the within To the comp	29b. Signature and title of certifier	ode			27898		. 1 1	(Month, Dey, Year)
	30. Name and address of person who a	. ANDRAL	PE 35	Print) MI	LL ST.	HAGE.	RSTOWN	U, MD 21740
State Registrar	31. Date filed (Month, Day, Year) JUN 0 5 20	32. Redistrar's	Signature 6.	Apa.	la			

State Registrar DHMH 16 Rev 6/95



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State Registrar

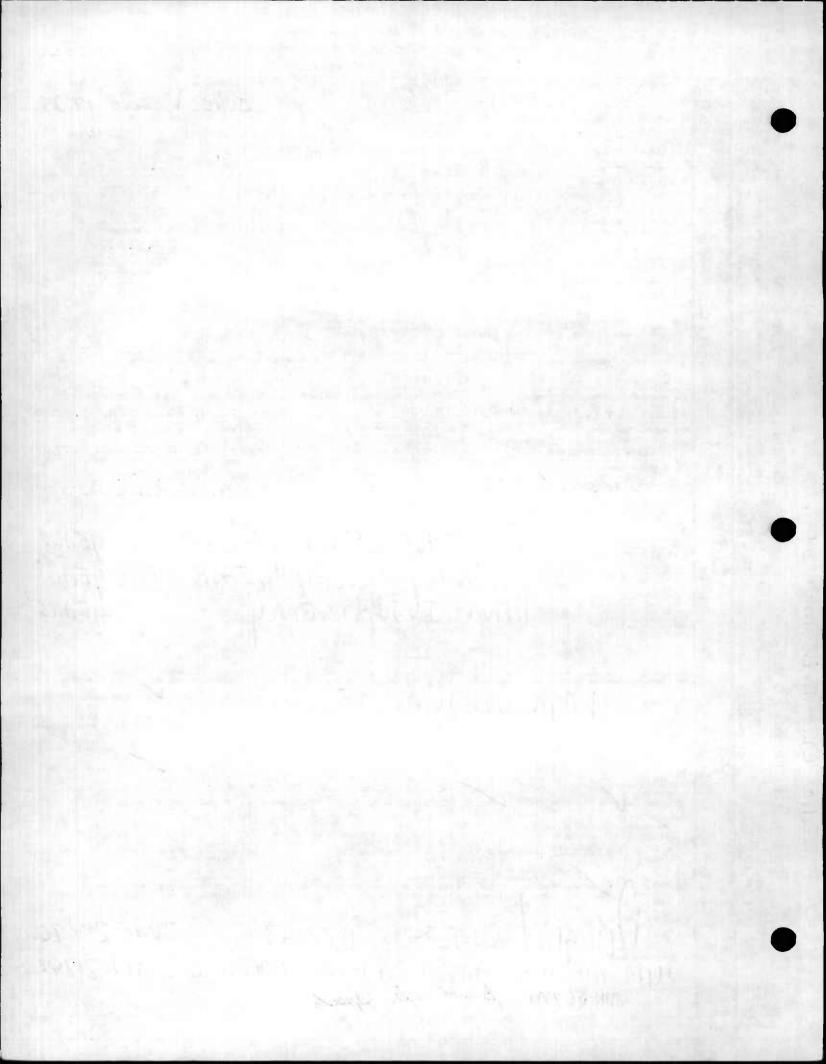
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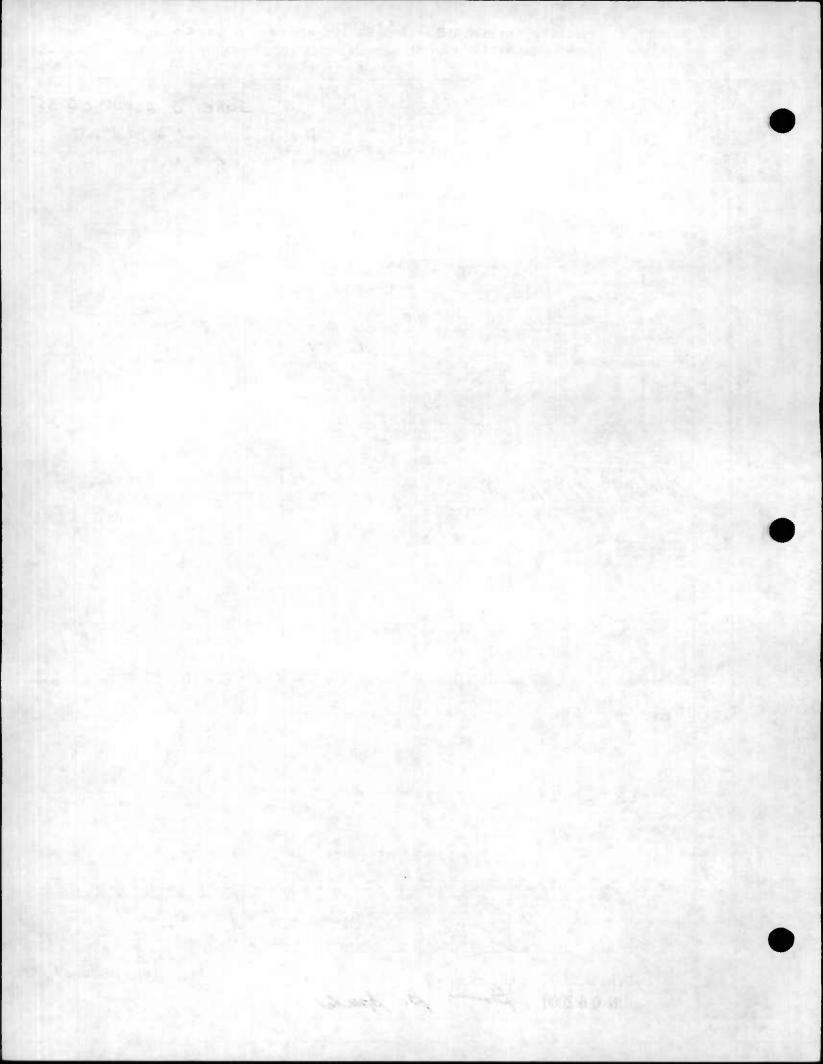


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			Certificate of	Death	Reg. No.	19052
Dh. alalas	1. Decedent's Name (First, Middle, Last,		( 1		of Deeth h Day Year	3. Time of Death
Physician /Medical	MARGARE	FRANCES M	-CARDE		e 3 2000	
Examiner	4a Facility Name (If not Institution, give			4b. City, Town, or Location of	(1)	
No.	5. Social Security Number 6. Sec	auty flos	t hirthday) If Under 1 Year	Hazers Lown	U DSF	
Funeral Director		Age (in yrs. ia)	Yrs. Months Days	Hours Min. (Mont	m, Day, Year) C	thplace (State or Foreign ountry) laryland
dand dand	10a. Stele 10b. County	10c. City,	Town or Location		-	10d. Inside City Limits
Men To To	Maryland Washingt	on Wil	liamsport			1 ☐ Yes 2 € No
vith the Me t or 28s-f s be notified Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?
th wi	16505 Virginia Ave	enue	21795		USA	
1215-0020 within 72 hours effer death with the Meryland ena. than 'natural', or items 23s or 28s-f show he Wedfer! Exercites must be notified at ampleted by Funeral Director	11. Maritat Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give WW2 Yeer or Dates:	1 Tyes 2 No	dispanic Origin? (Specify Yes an, Mexican, Puerto Rican, etc Specify:		
21215-0020 d within 72 hours of giena. Ir than "natural", or in world Error.	15. Decedent's Edu	cation	16e. Decedent's Usual Occur	pation	16b. Kind of Business	/Industry
faryland 21215-002 2 should be filed within 72 hours and Mental Hygiena. Is marked other than "natural; summitic event, in Medical Ex- aumatic event, in Medical Ex-	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	duning most of working d)		
yland 212 Viand be filed with Mental Hygiena, serked other the effic event, tree To Be Comp		1	Secreta		Federal Go	vernment
Maryland 2 d 2 should be filed th and Mental Hygi 7 is marked other traumatic event, i	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, M		
aryla should ind Men marke umatic	Leo Duhamel Thomp				gnes Collins	
Mar 12 sho is m	19e. Informant's Name/Relationship (Ty			and Number or Rural Route I		
Nore, Maryland 212 ges 1 and 2 should be filed within to Haalth and Mental Hygiena. If item 27 is marked other than or other traumatic event, the south of the traumatic event, the second other traumatic event.	Gerald N. Minnich 20a. Method of Disposition		305 N. Potoma	c St. Hagers	town, Marylan	d 21740
Baltimore, N permit. Pages 1 and Department of Haalth Important: if item 27 any injury or other to	1 Cx Burial 2 Cremation 3 R	emoval from Stete Cedar	netery, crematory or other pla C Lawn Memoria	al Park 6/9/00		
Bal permi Depari Import	21 Signature of European Service Ucens	mich	22. Nome and Addre Gerald N. 1 Funeral Hor	Minnich 305	N. Potomac St	
	23a. Pert1. Enter the disease, or complishock, or heart tailure. List only or	cations that caused the deeth.	Do not enter the mode of dying	ng, such es cardiac or respiret	tory errest,	Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	A systole  Due to (or a	s a consequence of):			Onset and Death
axecuted in and itel-transit	Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):			t 
6876( filcata be g physicia as tha bur	Cause (Disease or injury thet initiated events resulting in death) Last		s a consequence of):			 
Box path cart ottendin for use						
15, P.O. BO) res that the death or signed by the ettend the detected for us	Part II. Other significant conditions con	tributing to death but not resulti	ng In the underlying cause gi	ven in Part I. 23b	. Did tobacco use contribut	e to the cause of death?
thet the detection of t					1 Yes No 3 F	Probably 4 Unknown
v raqui been should				24a.	Wes an eutopsy performed?	Were sutopsy findings available prior to completion of cause of death?
The la					1 Yes 2100	1 Yes No
Vital Re- sician: The lav cartificate has lirector, page 2  o Be Comp	25. Was case referred to medical	1	and I	26. Plece of Death (Check	only one)	-
_ S D	exeminer?	lospital:   Inpatient 2   EF	NOutpatient 3 DOA	ner'	Residence 8 Other (Spe	ecify)
VISION O Attending Ph or death. ector: Atter th by the funeral	Mepher of Death Natural 5 Pending Accident investigation	28a. Dete of Injury (Month, Day Year)	8b. Time of Injury Mo	ry at rk? 28d. Des	cribe how Injury occurred	
Division of the or attending P is after death.  I Director: After the or in by the funers Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, fectory, office		tion (Street and Number or F or Town, State)	Rural Route Number,
n 24 hound n 24 hound n 24 hound ne Funer pletaly fill edical		sician: To the best of my knowled ner: On the basis of examinetion and manner stated.				
withi vithi com	29b. Signature and title of Certifier	1 11	29c. Licens	se number	29d. Date signed (Mor	oth, Day, Year)
	1/1/1 ), U	auem M.L	1 10	053071	JUNE	3,200
	30. Name and address of person who co	impleted cause of death (Item 2	3e) (Type, Print) COMPUS RA	. ste 226	Happitaw	N, NO 2174Z
State Registrar	31. Dete filed (Month, Day, Year) JUN 0 6 2000	32 Aegistrar's Signatur	b. Spark			

DHMH 16 Rev 6/95

Margaret Frances mecarden

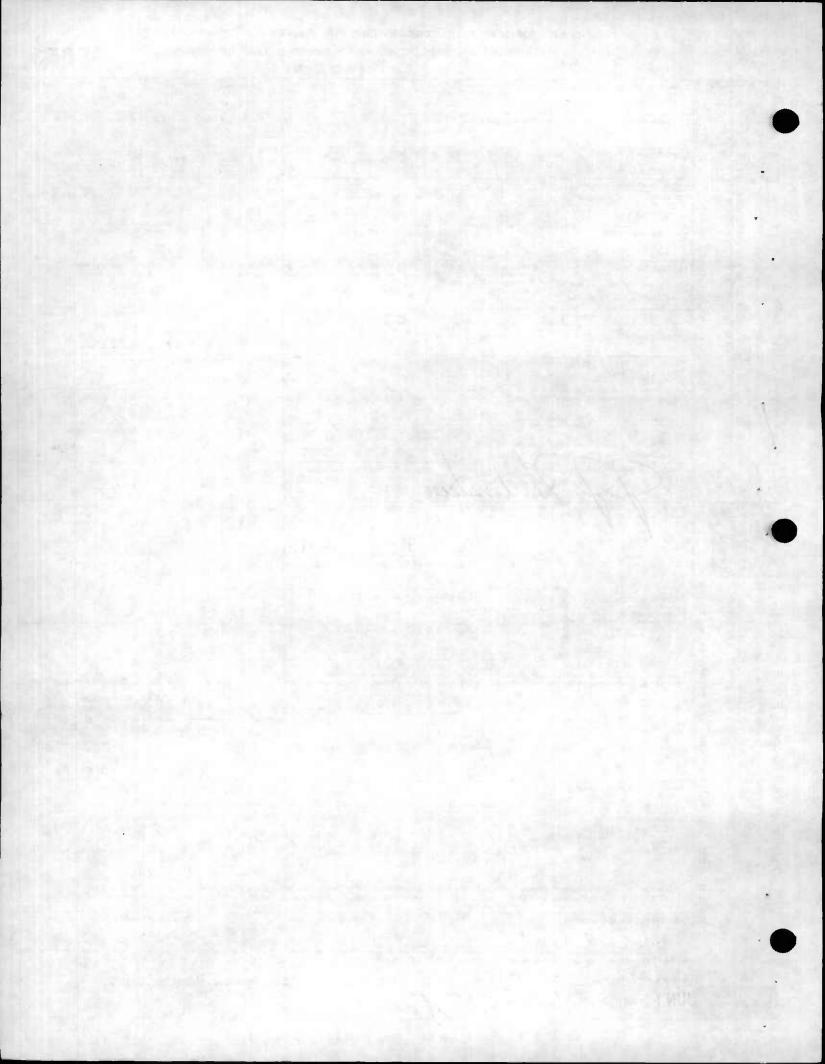


00-3081-005 jhm DANIEL A MC

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 10052

CORMACK				Certifica	te of	Death	,	Reg. No.	0 1903	00	
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel Anthony McCormick				2.			2. Data of Death Month Day Year		Death	
			At On Town and			3, 2000 18:35 I		PM			
						Parkton	on Location of Death On BALTIMORE				
Baltimore, Maryland 21215-0020  permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Deperment of Health and Mental Hygiene. Important: If Item 27 Ie marked other than *natural*, or items 23a or 28a-1 show any Injury or other traumetic event, the Medical Examples must be notified at one.  To Be Completed by Funeral Director	041-70-6060	Sex 1MM 2□F	Yrs. If Under	r 1 Year Days	If Undar 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug. 15	1963	9. Birthplace (State of Country) Connectic			
	Usuel Residence of Decedent  10a. State 10b. County	wn or Location					10d. Inside Cit	ty Limits			
	PA York	A York Yor			rk				1 ☐ Yes 2X No		
	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2549 S. George St. 17403 U.S.A.										
	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deceder Armed Force: 1 Yes 2 Married 1 Yes, Give Year or Dates		? If Yes, specify Cull No 1 ☐ Yes 2 No				pecify Yas or No- Pican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (		16a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)  Welder			pation during most of work d)	orking  16b. Kind of Business/Industry  Motor Cycle  Manufacturing				
	17. Father's Name (First, Middle, Last)							Middle, Maiden Surname)			
							ces Zifilippo				
							or Rural Route Number, City or Town, Stete, Zip Code)				
	Sharon A. McCormick/Wife 2549 S. George St  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)						Date		- City or Town, State		
	1 X Burial 2 Cramation 3 4 Donation 5 Oth			reedom C		· Ut	ne 8,	New F	reedom, PA		
	21. Signature of Funda Service Licenses  22. Nama and Address of Facility  J.J. Hartenstein Mortuary, Inc.										
	23a. Perti Enter the disease, or co shoot a heart bifure. List on	mplications that cause	ed the death. Do	not enter the mo	de of dyin	ng, such as cardiac	or respiratory ar	rest.	Approximate Interval Betv	e ween	
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)  Due to (or as a consequence of):										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physiclan/Medical Examiner		b								-	
	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury		Due to (or as a consequenca of):								
	that initiated events resulting in death) Last	Due to (or as a consequenca of):									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contributs to the cause of death								of death?		
	rait ii. Other arginineant continuons continuoning to death out not resulting in the uniderlying cause given in					ven in Fast i.	1 Yes 10 No 3 Probably 4 Unknown				
							24a. Was an autopsy performed?  24b. Ware autopsy fit wailable prior to completion of ce of death?			0	
							Des	res 2 No	Mes 2□	No	
	25. Wes cese referred to medical examiner?					26. Place of Dea	th (Check only o	ene)			
	1 √ Yes 2 No 27. Manner of Death	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify) SCENE									
	1 Netural 5 Pending	28a. Deta of Injury (infantry Day Year)  28b. Time of Injury at Work?  1 Yes 2 TNo More Control of Injury at Work?							0		
	3 Sulcide 6 Could not determine	4   200 [Place of th	28e Plade of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, or Town, State)				
	29a. Certifier (Check ent)  (Ch										
	29b. Signature and title of ceptifier 29c. License numb					se number	29d. Date signed (Month, Dey, Year)				
	(awtobead)				OCM	E		JUNE 04, 2000			
	30. Name and addrass of person who		death (Item 23a)	(Type, Print)			100				
Chata	Pate filed (Month, Day, Year)	32. Regist	1] ray's Signature	1 Penn	Stre	et, Balti	more, M	aryland	21201		
State	JUN 1.5 2000	a a	4								



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

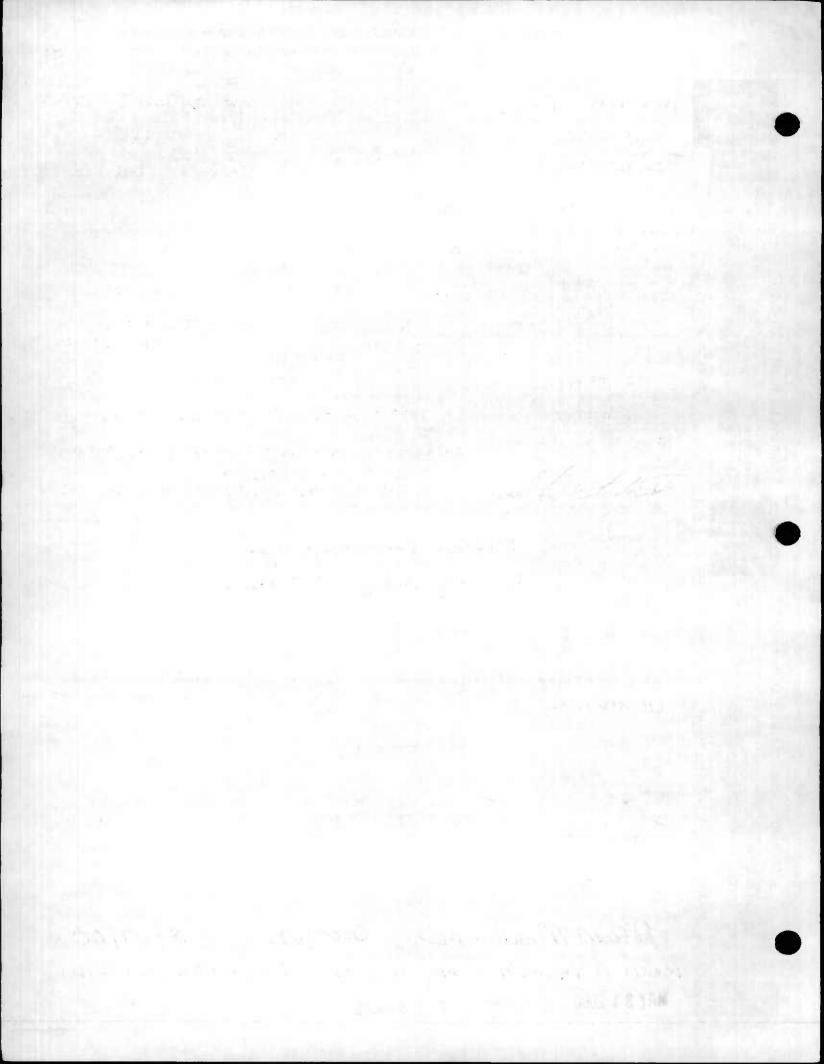
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth 2F00 Year **Physician** Month 27 Pooce 00:30 mitchell /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Elkton Cecil If Under 1 Year 5. Scalal Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Hours Min. 15 M 2□ F 222-03-2783 79 Director 1-29-1921 Delaware Usuel Residence of Decedent show 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, ins Mexical Experiment must be notified at once. Md. Cecil Elkton Director 1 TYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 Bridgewell Drive Apt. 8 21921 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. XYes 2 No
If Yes, Give
Year or Dates: WWII 1 ☐ Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2ONo Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cecil Co. Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 0 Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Sumeme) Be Joseph Poore Emma Howell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Pat Slaughter 1239 Slaughter Station Rd. Hartly, DE. 19953 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Delaware Vets. Cemetery 6-1-00 Bear, Delaware 21. Signeture of Funeral Service DANIELS & HUTCHISON N. Broad st., Middletown, DE. 19709 23a. Part1. Enter the disease, or complicators that cauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse accept the Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Ischemic Cardiomyopathe Examiner Due to (or as a consequance of): Coronary artery

Due to bras a consequence of): The law requires that the death certificate be executed Exami Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last -traf ettending physician a for use as the buriel-Box 68760. Physician/Medical Due to (or as a consequence of) P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1ementio Records, þ 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was en eutopsy performed page 2 s this certificate 1 Yas 2 No 1 Yas 2 No Division of Vital Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28c. Injury et Work? 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Natural Injury 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide 1 Tertifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier Medical EP. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Roberta. Wonteleane MD D0053675 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 6+18A A. Morteleone, MO III W. High St. Suite 310, Elkton, MO 31. Date filed (Month, Dey, Year)
MAY 3 1 2000 32. Registrar's Signatura State Registrar

DHMH 16 Rev 6/95



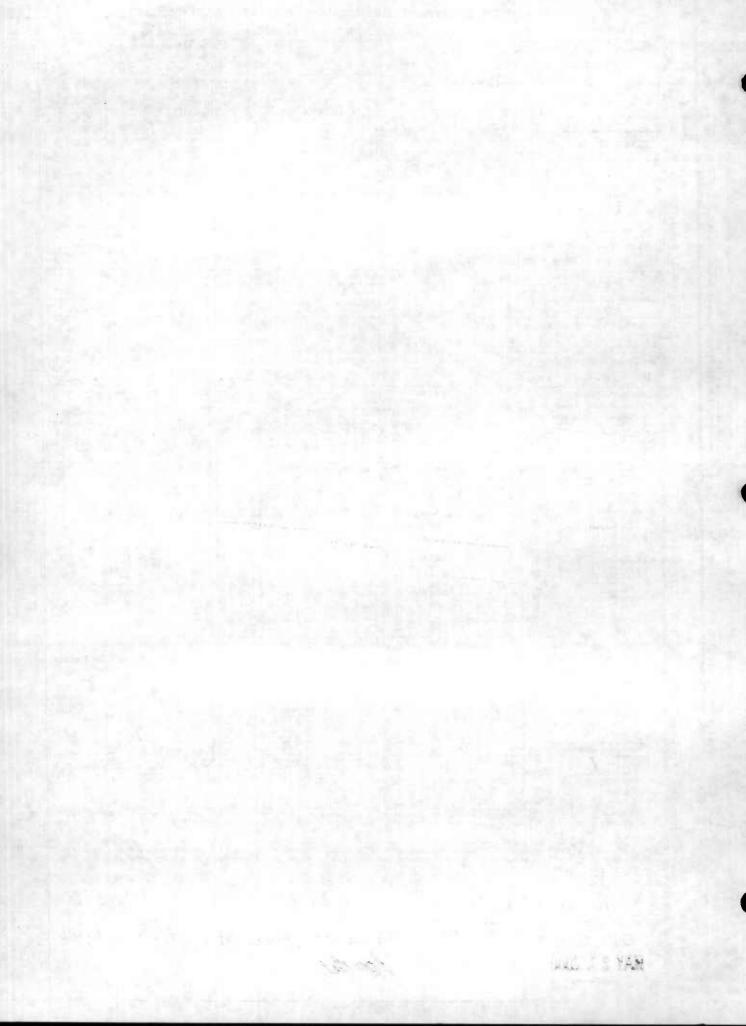
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene amend item 5 per fh G784 6/23/00 yg Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Zelma Pearl Potter 27, 2000 May 4:27 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 56 A Hollingsworth Manor Ceci1 Elkton If Under 24 Hrs. If Under 1 Year 8. Date of Birth 9. Birthplace (Month, Day Year)
July 15,1931 North 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 68 Director Carolina Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Peges I end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item 23a or 28a-f show eny injury or other treumatic event, the Medical Examinat must be notified at Md. Cecil Elkton Yes 2 □ No **Funeral Director** 10a Street and Number 10f Zin Code 10g Citizen of What Country? 56 A Hollingsworth Manor 21921 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Assembly line RMR Corp. 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Earl Donnelly Ellison Mabel Main 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Butler , Cousin 609 E. Pulaski Hwy., Elkton, Md. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 Kurial 2 Cremation 3 Removel from State Church of Christ Cem. 5/30/00 Elkton, Md. 4 ☐ Donation 5 ☐ Other (Specify) 259 E. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Main Street, Gee Funeral Home Elkton, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) r9a Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) ettending physician Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 XYee 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 Yes 2 No certificate or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this 28a. Dete of Injury (Month, Day Year) edical Certification: 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral C
completely filled To the Hospital to Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jui clil Hu MD 30/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUI CHIH HSV MD 223 W. 84 mais st. Elleta, Md 21921 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month Year ELEANOR 2000 GAIL PERRY 1, June 0945 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Graham Nursing 1203 Old Telegraph Rd. Warwick Cecil Home last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Dey, Year) 7. Age (In yrs. Days Months 1□ M 200F Yrs. 233-30-0597 -13-1925 W. Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Delaware New Castle Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 E. Green Street 19709 USA 12. Was Decedent Evar In U,S. Armed Forcas? 1 Yes 2\( \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Black, White, etc. 1 t. Marital Status 1 Never Married 2 X Married 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 12 18. Mother's Name (First Middle, Meiden Sumama) Helen Logston 17. Father's Name (First, Middle, Last) Lloyd S. Tebay 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Gilbert Perry 109 E. Green Street, Middletown, DE. 19709 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Capitol Cremation 6 + 2 - 00Dover, Delaware 22. Name and Address of Facility DANIELS & HUTCHISON FUNERAL HOME 21. Signature of Funarai Sarvice Licensee 212 N. Broad Street, Middletown, DE. 19709 Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) CVA Due to (or as a consequence of): ATRIAL fibrillaTIO1 Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 2 0 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1 Yes 2 No 25. Was casa referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpetient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28c. Injury et Work? 28b. Time of 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Examiner attending physician end for use as the burial-transit P.O. Box 68760 Physician/Medical s been signed by t 2 should be detach Records. þ Completed page 2 certificate Division of Vital Be this funeral After

**Physician** 

/Medical

Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

ò

Completed

Be

2

**Funeral** 

Director

death with the Maryland

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28s-1 show any injury or other traumatic avent, the Medical Examiner must be notified at once.

Saltimore, Maryland 21215-0020

or Attending Parter death. To the Mospital or Atte within 24 hours after dea To the Funeral Director completely filled in by the

State

Medical

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Prinf) William Covell 817 N. Broad street, Middletown, DE. 19709 31. Date filed (Month,

4 Homicide

29b. Signature and title of certified

29a. Certifier (Check only one)

32. Registrar's Signature

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

🖔 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

C1 0005656

29d. Date signed (Month, Dey, Year)

6/2/00

Registrar DHMH 16 Rev 6/95

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Paul M. Pennington June 1, 2000 3:30 P.M. /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 244 Hutton Road Elkton Cecil 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year) 5. Social Security Number Birthpiece (State or Foreign Country) **Funeral** Days XXM 20 F 47 215-58-4780 **Director** September 1,1952 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Cecil Elkton NYes 2 No 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or must be 17 Leedom Road 21921 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes ♣ No Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ lf Yes, Girl Year or Dates: 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Horse Farm 12 Maintenance Supervisor permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If Nem 27 is marked other any Injury or other treumetic avains 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Harold L. Pennington Mary Chicosky 19a. fnformant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Samuel Pennington(Son) 17 Leedom Rd. Elkton, Md. 21921 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date tX Burial 2 ☐ Cremation 3 ☐ Removal from State St. 6/5/00 Chesapeake City, Md. Rose of Lima 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Perpetal Service 22. Name and Address of Facility Licensein Gee Funeral Home 259 E. Main St. Elkton, Md 21921 23a. Part1. Enter the divises, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a. Metastatic Papillary Adenocarcinons
Due to (or as a consequence of): 5 Months Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or es e consequence of): P.O. Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 24a. Was an autopsy performed? After this certificata has 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Plece of Death (Check only one) AUNTS Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Hother (Specify) RESTDENCE 1 Yes 2 No Medical Certification: To luneral 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division or Attending 1 Metural 5 Pending investigation i after death.
i Director: After in by the fu 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and manner steted. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Morte Makow , MD 0-44783 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West High Street, ELKTON, MD 21921

Registrar **DHMH 16 Rev 6/95** 

Monte Makour, MO

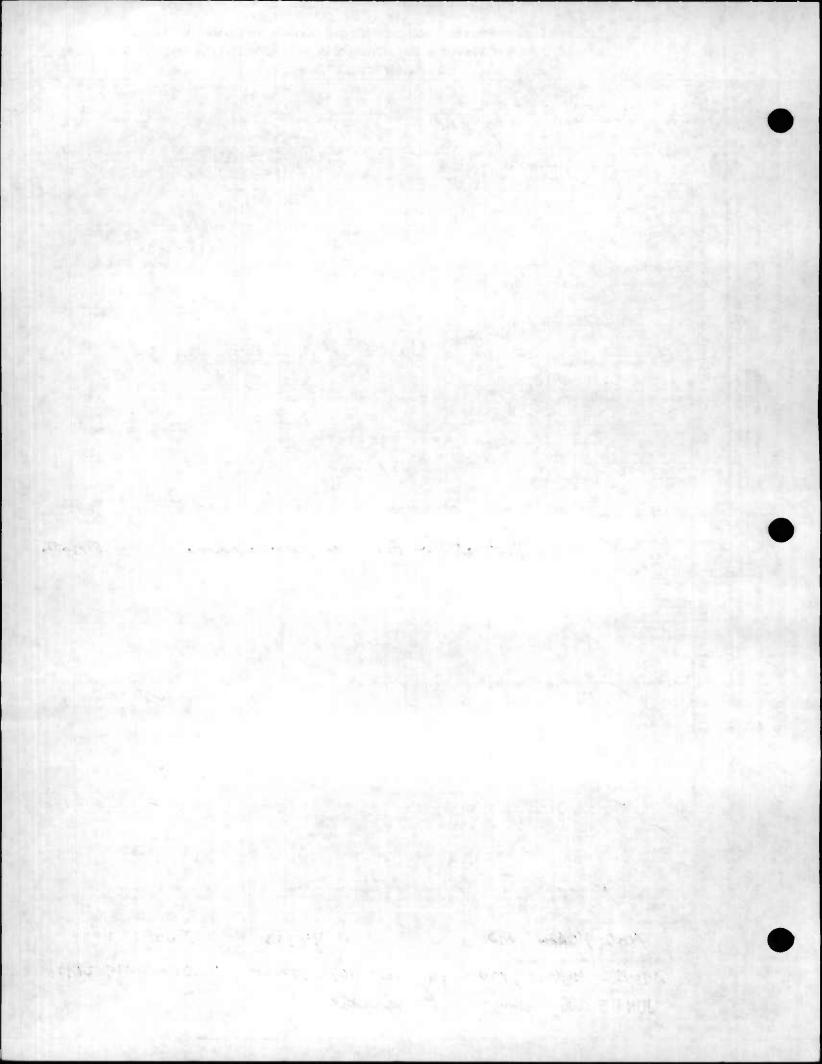
31. Dete filed (Month, Day, Year)
JUN 0 5 2000

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Dam

111

32. Registrar's Signature



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) Day Month Year **Physician** Cecil F. Pierce, Jr. June 2000 9:10 am /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Harford Memorial Hospital Haure de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Months, Dey, Year) Jan. 3, 194 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 218-38-3762 58 Maryland Usual Residence of Decedent 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Cecil Conowingo 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zin Code 7 Shady Lane 21918 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: þ Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Cecil Franklin Pierce. Sr. Helen Claire Little 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Cecil Wayne Pierce/Son 47 Chatham Lane Elkton, MD 21921 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Brookview Cemetery 6-7-00 Rising Sun, Maryland 22. Name and Address of Facility T. Foard Funeral Home, P. A. 21. Signature of Funerel Service Licensee 111 S. ichard Queen St., Rising Sun, MD 21911 caused the deeth. Do not enter the mode of dyling, such as cardiac or respiratory errest, Approximete tntervel Between Onset end Death Enter the disease, or complications, or heart feiture. List only one cause Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or as e consequence Physician/Medical 23b. Did tobacco use coptribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yes 2010 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat Be 26. Plece of Deeth (Check only one) SPIN Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitet: 1 Impatient edical Certification: To 1 Yes 2 ER/Outpetient 3 DOA 27. Menner of Death 1 Netural 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Funeral

Director

288-1

23a or

8

Hygiene.

Pages 1 and 2 should be fill trant of Health and Mental H tant: If Nem 27 is marked off

Department of Health Important: If Item 27.1

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0020

State Registrar

**DHMH 16 Rsv 6/95** 

page 2 s

this

Affer 1

death.

after death Director:

within 24 hours

To the

completely

29e. Certifier

filed (Mooth, Dev. Year) JUN 0 6 2000

30. Name and address of person who completed cause of death (Item 23a) (T)

29b. Signeture and title of certifier

32. Registrar's Signetur

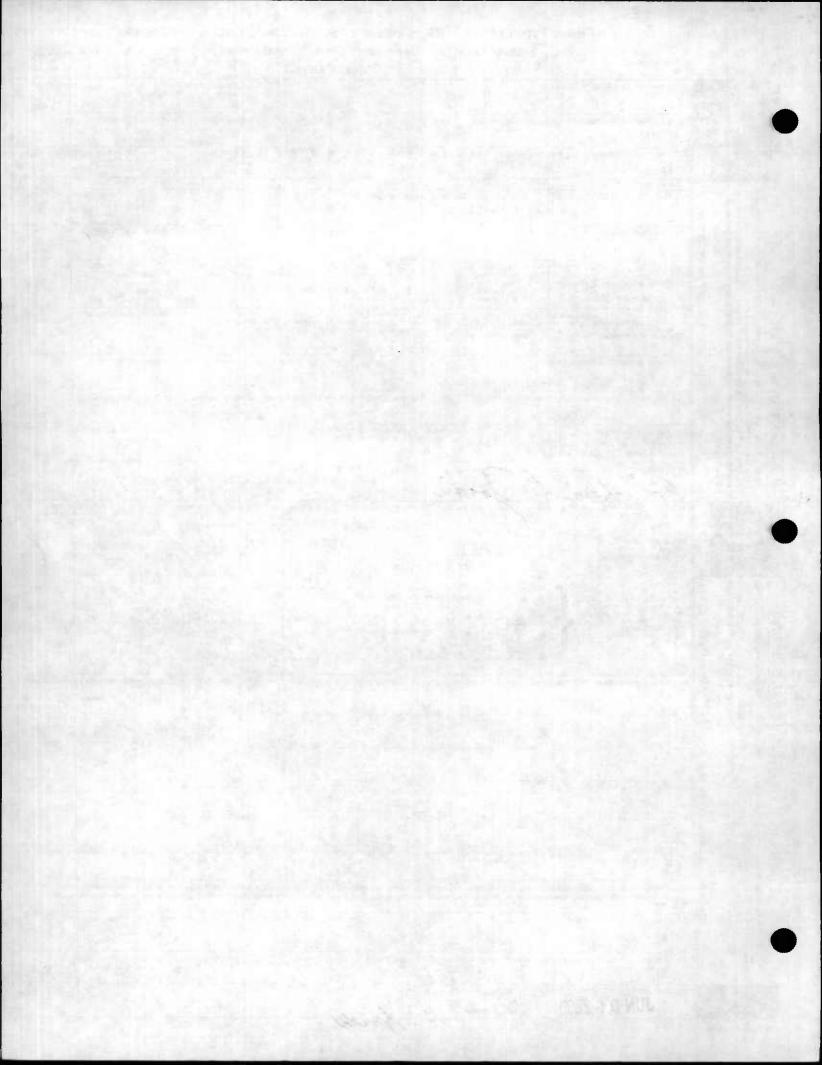
**ORIGINAL** 

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dey, Year)



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

							ertificate o	f Death	Re	eg. No.		9059
	Physician	1. Decedent's Name (Fir Rita Peaco		st)					2. Dete of Deat Month	Day	Year	3. Time of Death
100	/Medical	4a Facility Name (If not		o attact and nu	m floor)			4b. City, Town, or	June 3	4c. County	of Death	6:01 pm
	Examiner	Laurel Regi						Laurel				orge's
	Funeral Director	5. Social Security Number 229–80–5232	er 6. S		7. Age (In yrs. 62	lest birthda Yrs.	y) If Under 1 Yea Months Day	ar If Under 24 Hrs				lace (State or Foreign try)
	DQ	Usual Residence of Dec	edent . County		10c Cit	ty, Town or	Location				16	0d. Inside City Limits
	Sa-f sho	Md. Pr		George's		aurel				- ah		1□ Yes 2XXNo
	uter death with the Meryland r items 23s or 28s-1 show rest must be northed at Funeral Director	10e. Street and Number 13026 Old 5	Stageco				10f. Zip Code 207	08		Og. Citizen of V	ny	
020		11. Marital Stetus  1 Never Married  3 Widowed 4		12. Was Deci	2 XNo	,S. 13	If Yes, specify Co	f Hispanic Origin? (Suban, Mexicen, Puerlo Specify:	o Ricen, etc.)		e - America ck, White, d	
5-0	72 ho	15. (Specify or	Decedent's E	ducation ade com <i>pleted)</i>		16a. Dec	edent's Usuai Occ ve kind of work don	cupation ne during most of wo ired)	rking	16b. Kind of Bu	usiness/Ind	lustry
2121	be filed within 72 hours of the Hygiene. I dother than "naturel", of event, the Medical Examerer, the Medical Examerer.  Be Completed by	Elementary/Secondary Grade 12	T	College (1	1-4or 5+)		DO NOT use reti			Own		
Pu	Be Be	17. Father's Name (First,	, Middle, Last,	)				18. Mother's Na	me (First, Middle, M	Maiden Suman	10)	
aryla	s marke s marke sumatic	Franz Josep 19a. Intormant's Name/F	oh Kunz Relationship (	Type, Print)		19b. Ma	iling Address (Stre	Apollo	nia_Hinke	City or Town,	Stete, Zip	Code)
J W	and and a salth n 27 i	Kenny Peaco		· / s	son		) Wetherb		Woodbrid			
OEA COCK Baltimore, Maryland 21215-0020	Peges 1 nent of H int: If iten iry or off	20a. Method of Disposition  1 Burial 2 Cre 4 Donation 5	emation 3		State		position (Name of remetory or other p Cremator		June 5 2000	20c. Location -		
OE Balt	permit. Depertriction of the control	21. Signature of Funeral	1.0		/ MOO77		22. Name and Add Donaldso	n Funeral	Home D	λ		
4		23a. Part1. Enter the dis shock, or heart fail	sease, or com	plications that c	aused the dea	th. Do not e	313 Talk	ott Avenu lying, such as cardie	e Laure c or respiretory error	L, Mary	land	20707 Approximate Interval Between
1	Physician	shock, or heart tast	ure. List phly			_						Onset and Death
&	/Medical Examiner	Immediate Cause (Final disease or condition		. 0	EKEB	3 Ro	VASCU	LAR A	CCI DE1	VT		4 DAY
		resulting in death)			Due to (	or as a cons	sequence of):					
	icate be executed physician end sthe buriel-transit	Sequentially list condition if any, leading to immediceuse. Enter Underlying Cause (Disease or injury	ns, iate	b	Due to (	or as a cons	sequence ot):					
ox 68760,	5 00 0	Cause (Disease or Injury that initiated events resulting in death) Lest	1	d	Due to (d	or es e cons	equence of):					
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0.9	the death ce death ce death ce de by the ettendiletached for use			7510	_				1 U Y	es 2 No	3 Prot	bably 4 Lunknow
ords, 1	v requires that the death cer been signed by the ettendir should be detached for use steed by Physician/A	7 7 7 3	-1	s M		rus			24a. Was a		ava	ere autopsy findings ailable prior to
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ta	entifica sctor, p	25. Was case referred to examiner?	medical					26. Place of De	ath (Check only or	16)		
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o u	Miter ti unera unera	27. Manner of Death 1 🕒 Natural 5 [	Pending		ot Injury th, Day Year)	28b. Time injun		njury at Vork?	28d. Describe ho	ow injury occur	red	
Division of Vital Records, P.O. Box	tal or Attending Programmers attended th.  al Director: After to led in by the funers  Certification:	2 Accident 3 Suicide 6 4 Homicide	Investigatio  Could not be determined	e 28e. Piace	of Injury - At h	ome, farm, fy)	M 1 street, factory, office	Yes 2 No	28f. Location (Si City or Town		ber or Rure	il Route Number,
	To the floatial or Attending Physician: The is within 24 hours eler death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 15 (Check only 2 one)	Certifying Ph Medical Exar	ntner: On the b	best of my kno asis of examina ner stated.	owledge, de ation and/or	ath occurred at the investigation, in m	time, date end plac y opinion, death occ	e, and due to the curred at the time, d	ause(s) and ma ate and place,	anner as st and due to	lated. the cause(s)
	To the comple	29b. Signature and title	of certifier	12 F	Herd	Pho	29c. Lice	ense number	7	9d. Date signe	d (Month,	Dey, Year)
	10	30. Nameland address of	ot persopywho	completed caus	se ot death (Ite	m 23a) (Typ	B. Print) FR	PARKU	JAY GR	EEN (	3EL-	T MO
190	State Registrar	31. Dete tiled (Month, D	ey, Year) JN 0 6	32. F	legistrar's Sign	ature	5. So	2010/				10-173

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Data of Death June 3, 2000 Year **Physician** George Allen PHIPPS 10:55 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing Center Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 23, 1932 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 213 30 5818 68 Yrs. Director Usual Residence of Decedan 10a. State Calvert 10c. City, Town or Location 10d. Insida City Limits Friendship 1 Yes 200No Director 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ŏ 7086 Prout Road 20758 238 USA Harris . 12. Was Decedent Ever in U,S. Armed Forces? 1 IXYes 2 □ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - American Indian 11. Marital Status Black, Whita, atc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0020 ò 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) truck driver transportation 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be 1 and 2 should be Health and Mental George Allen Phipps Iva Celeste Brady permit. Pages 1 and 2 as Department of Health and Important: If Item 27 is ma any Injury or other to 2009. 19a. Intormant's Name/Ralationship (Type, Print)
Mattie L. Phipps (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 above 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 6-6-00 Davidsonville, MD 4 □ Donation 5 🖾 Other (Specify) Entonoment 21. Signature of Funeral Service Licenses 22. Nama end Address of Facility Rausch Funeral Home, Owings, MD 23a. Part I. Enter the disease or complications for faused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical neumovice week Examiner Due to (or as a consequence of): Physician/Medical Examiner Colon CarcinomA physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) House iver P.O. Box 68760. Due to (or as a consequence of) Syndrome avaneoplastic Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 200 No 3 Probably 4 Unknown hellectennon Records, þ 24b. Wera autopsy findings available prior to complation of causa of death? Be Completed 24a. Was an autopsy is certificate h 2000 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician:
 124 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director. 25. Was case referred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 KNatural 5 Pending investigation 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Certifier (Check only one) within 2 To the \$ 29c. License number 29d. Date signed (Month, Day, Year) pal 742049 June 10

Registrar

State

1 VA

MO.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

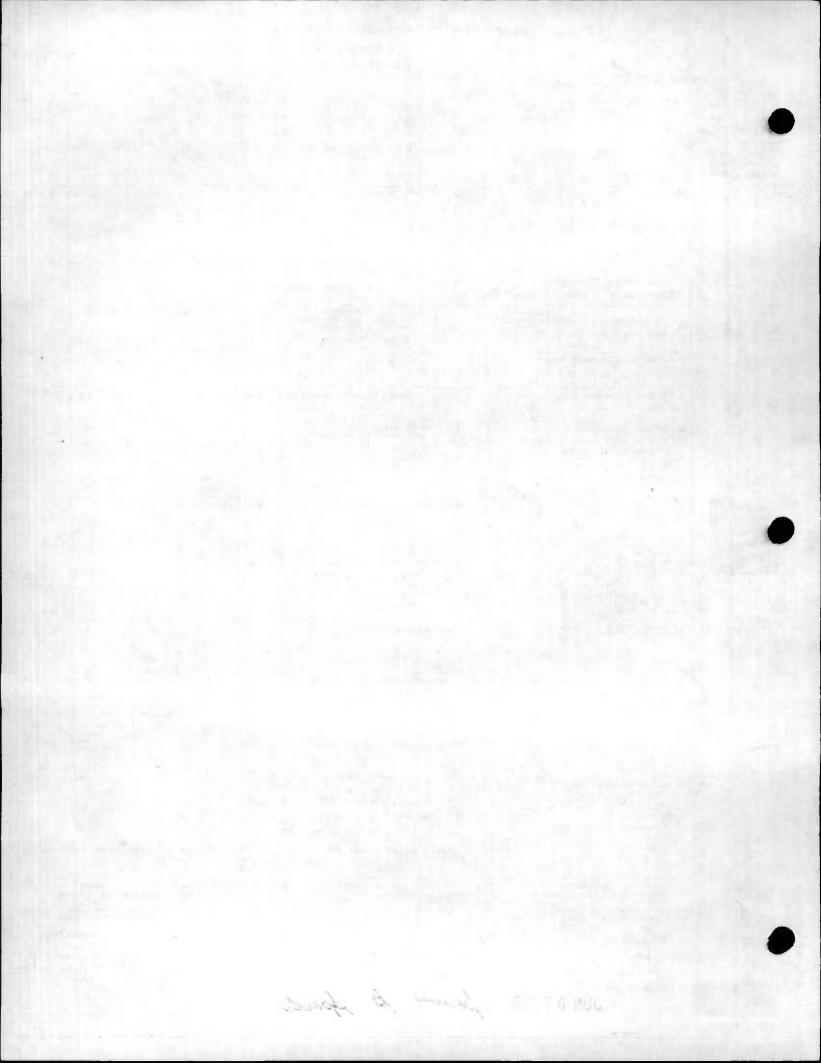
32. Registrar's Signature

Alain. G. CHAMPALOUX

JUN 0 7 2000 D

31. Data filed (Month, Day, Year)

Oppe MARIBOVO. Md. 20772



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 19061

						Cei	tificate	of L	Death		F	leg. No.		
		1. Decedant's Na	ame (First, Middle,	Last)							ate of Dea	ith		3. Time of Death
	Physician	John	Luft Re	enner.	Jr.					-	onth ne	Day	Year 000	2:30 P
4	· /Medical Examiner		e (If not institution,					4	b. City, Town,				y of Death	2.30 1
	Examine		Candle						Hac	gerst	own	Wash	ingt	on Count
1	Funeral	5. Social Security	y Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Y		If Under 24		ata of Birth Month, Day			place (State or Foreign ntry)
н	Director	212-24-	-7289	1 <b>X</b> M 2□ F		69 Yrs.	Months D	ays	Hours A	viin. (A	<i>Month, D</i> ay	, Year)		yland
н		Usual Residence	a of Decedent								211.10	11001	LELL	yıana
	show	10a. Stata	10b. County			, Town or Lo								10d. Inside City Limits
	r 28a-f show motified at	MD	Washin	gton Co.	Hag	gerstov	vn							1 ☐ Yes 2 No
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	h wit	18221	Candlew	ood Lane	9				2174	40	101	Ţ	J.S.A	•
	iter death with the Mai r items 23e or 28e-f si cher must be notified Funeral Director	11. Marital Status	s	12. Was De	cedant Evar in U,	S. 13. \	Vas Deceden	t of H	ispanic Origina n, Mexican, Pu	? (Specify )	es or No-	14. Ra		can Indien,
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02	led within 72 hours or sygiene.  We than "natural, or it, the Medical Even or	3 ☐ Widowed	d 4 Divorced	If Yes, C Year or	Dates:		I□Yas 2⊠	No	Specify:			Specia	fy: WII	ite
2-0	2 ho	100	15. Decedent's	Education		16a. Deced	lent's Usual O	ccup	ation during most of	wating		16b. Kind of E		
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21	d wil	1	0	0		Self	employ	red				Coal &	Conc	rete
b	Se veri	17. Father's Nem	ne (First, Middle, L.						18. Mother's	Name (Firs	t, Middle,	Maiden Suma	me)	
<u> a</u>		John Lu	ft Renne	r, Sr.					Mary	Morgi	ret			
Maryland 21215-0020	d 2 should th and Mer 7 is merks traumetic To	19a. Informant's	Name/Relationshi	ip (Type, Print)		19b. Mailir	ng Address (S	treet	and Number o	r Aural Aou	rte Numbe	r, City or Towr	, State, Zij	p Code)
	alth a	Beverly	Jeanne 1	Renner		1822	21 Cand	lle	wood La	ane, I	Hager	stown,	Mary	land 21740
Baltimore,	f He filem other	20a. Method of D			0.0	lece of Dispo	sition (Name in natory or other	of .		Da		20c. Location		
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-		199		71									, Mary	land 21742
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	Physician	tdiata Caus	o /Final	1	,	Λ				1				7
-11	/Medicar Examiner	tmmediate Caus disease or cond resulting in deati	ition	a. Ch	whit	lys	notw	CH	te	leu	lier	nea	1	Sycars
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a	certificate rector, pag	25 Mas 2000 50	formed to madical	LOVE					PI 1	D = 101				
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Division of	Physic chis chis chis chis chis chis chis c	1 Yes 2		1		ER/Outpatien 28b. Time of			4 LI Nursir	-		lence 8 Ot		(y)
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	the family and a plet	one)		and ma	inher stated.									
	or or or	29bBignature a	nd title of certifier	11	/ _		29c. L.	cens	e number			29d. Date sign	ed (Month	, Day, Year)
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		30. Name and ac	ddrass of person w	no complated car	usa of daath (Itam	23a) (Type,	Print)			. ^		Λ.	17	1
		1-11	dere 1	+ Kes	STILL	1 In	11101	~	educe	1 Ca	whe	s Kd	'tege	n howa ha
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	Registrar		JUN 022	000		12.	popol	1						

DHMH 16 Rev 6/95

THE PERSON WAS DESIGNATED IN Total Comment of the The state of the s

Amended Item#27 perPHYG786 8/29/2000 EW

			1. Decedent's Neme (First, Middle, La	ist)				2. Dete of Dec			3. Time of Deeth
	Physic		JO.	AN MARIE	RODMAN			June	1, Dey 2	000	3:35 P.M.
	/Medi Exami		4e. Fecility Neme (If not institution, gh	ve street end number)			4b. City, Town, or L Crisfi	ocation of Deeth	4c. County		
	E				yrs. lest birthday)	If Under 1 Yea		8. Dete of Birt			
	Funeral Director			1□ M 2 <b>X</b> F 6		Months Dey		March 1	v Year)	Mai	olece (State or Foreign ory) cyland
	show		10a. Stete 10b. County	100	. City, Town or Lo	cation					10d. Inside City Limits
	with the Maryland a or 28a-f show	ţ	Maryland Some	rset	Cr	isfield					1 <b>™</b> Yes 2 □ No
	or 28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	Whet Cou	ntry?
			21 W. Main Stree	t			21817		U	.S.A.	
	Items Iner mer mer mer mer mer mer mer mer mer m	Funeral	11. Maritel Status	12. Wes Decedent Ever Armed Forcas?	in U,S. 13. \	Was Decedant of	Hispenic Orlgin? (Sp ben, Mexican, Puerto	pecify Yes or No-	14. Rac	e - Americk, White,	can Indien,
020	ours aft	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorcad	1 ☐ Yes 2 No If Yes, Give Year or Detes:		1□Yas 2XIN				Whit	
5-0	n 72 hours "natural", eoiral Ex	etec	15. Decedent's E (Specify only highast gr	ducation ade completed)	16e. Deced	lent's Usuet Occ kind of work don	upetion e during most of work	kina	16b. Kind of B	ustness/In	dustry
12	within ene. than	Completed	Elamantary/Secondary (0-12)	Collage (1-4or 5+)			e during most of work red)		_		
2	Hygie her t	ပိ	12 17. Fether's Nema (First, Middle, Last		Sal	es Lady	18. Mothar's Nam	on /First Middle	Depart		Store
Maryland 21215-0020	nd 2 should be tried within alth and Mantal Hygiene. 27 Is marked other than is traumatic event, the Mantal and	To Be	Ervin Bonner Am			_	Mabel T		Meloen Sumer	110)	
Aar	and and ls ma		19e. Informant's Name/Reletionship		1		et end Number or Ru			State, Zip	Code)
	Haalth Haalth Iam 27 I		Donna L. Ward (				Street - C	T		21817	
$\overline{}$			20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐	Removel from State		netory or other p		Dete	20c. Locetion		
ti m	tmen tant: jury		4 Donation 5 Other (Special		Salisbur		-	/3/00	Salis	bury,	MD
Baltimore,	permit. Pages Department of Important: If It any Injury or once.		21. Signelura Fuperal Service University Robert H. Brad	workers	B		ress of Facility & Sons Fu ain St. –			2181	7
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the						2101	Approximete
_ P	hysician		SHOCK, OF HEART REMOTE. LIST OFFIN							1	Intarval Between Onset end Daeth
10	/Medical		Immediate Cause (Finel disease or condition	net 5	fet e	Brecist	Cuci.				fyear,
•	Examiner		resulting in daeth)	a	to (or es e consec						
-	D #	ine	_	b							
	aam canincata be axecuted attending physician and for use as the bunal-transit	Examiner	Sequentially list conditions,	Due	to (or es e conseq	uenca of):					
68760,	cian		Sequentially list conditions, if eny, laeding to immedieta ceuse. Entar Undarlying Ceuse (Disease or Injury	C							
287	physic the	dic	thet initieted events resulting in death) Lest	Due t	o (or es e conseq	uenca of):					
×	aam cannic attanding pi for use as i	clan/Medical		d							
Вох	attan	clar								1	
P.O.	y the	Physi	Part II. Other significant conditions of	onfributing to death but not	rasulting in the u	nderlying cause (	given in Pert I.				o the cause of death?
О.	mar ned by deta	by Pt						10'	/es 2 100	3 Pro	bably 4 Unknown
rds	vequires that the debate the should be detached	D D						24a. Was	en eutopsy	24b. W	ara autopsy findings
၀		Completed						perfo	med?	co	reiteble prtor to impletion of cause deeth?
Be :	m - C - W	E						101	as 2000		Yes 2□ No
ta	certificata rector, pag	BeC	25. Was case referred to medical				26. Plece of Dae		-	1	J 165 20 NO
> 1	this certific ral director,	ToB	examiner? 1 ☐ Yas 2 ☐No	Hospital: 1 ☐ Inpatient	2 ER/Outpetien	t 3□ DOA	Whor:	ome 5 Resid		ar (Snach	(v)
0	£ 5 8		27. Menner of Death	28a. Dete of Injury (Month, Day Yea		28c. tn		28d. Describe h			,,
0	Attanding r r death. actor: Aftar by tha funer	atio	1 ☑Naturat 5 ☐ Panding 2 ☐ Accident invastigatio		r) Injury		Yas 2 No				
Division of Vital Records,	after de Directo	Certification:	3 Suicida 6 Could not b 4 Homicida datermined		At home, ferm, streecity)	eet, fectory, offic	0	28f. Location (S City or Tox	Street end Numi m, Stete)	ber or Run	el Route Number,
	within 24 hours after death.  To the Funeral Director: A completely filled in by that	Medical C	29a. Cartifier (Check only one) 1 Cartifying Ph	ysician: To the bast of my ninar: On the besis of exam end mennes steted.	knowledge, deeth	occurred at tha restigetion, in my	time, date end pleca, oplnion, death occur	, end dua to tha c rred et the time,	causa(s) end m date end place,	enner es s end due l	teted. the cause(s)
4	ithin o the omple	Me.	29b. Signature and title of certifier	ond marine stoted.		29c. Lice	nse number		29d. Dete signe	d (Month.	Dey, Year)
•	- <b>s -</b> 0		1 41	/at	M.O.	/	2 3069.		June		
5			30. Name end address of person who	completed cause of deeth (	(Item 23e) (Type	Print)				,	2 - 0
			James B. Mart	M. 2. 145	E. Carr	o11 St	- Salishu	rv. MD	21801		
				143	D. COLL	J44 DU.	DUTTON	m 1 1 11D	21001		

32. Ragistrer's Signature

**DHMH 16 Rev 6/95** 

State Registrar 31. Date fited (Month, Day, Yeer)

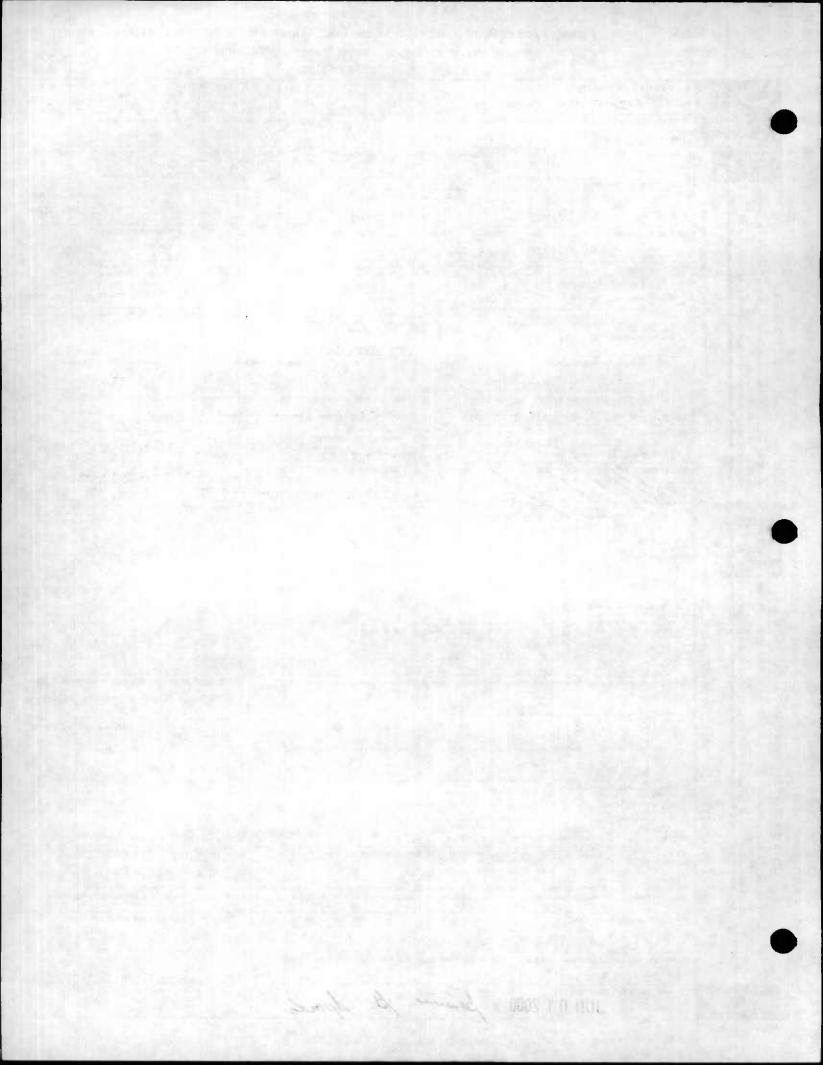
JUN 0 5 2000

NEW WITH WATER

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		Decedent's Name (First, Middle, Last)		Certificate of	2. Date of	Reg. No.	3. Time of Death
	Physician	Charlotte K	ave Raim		Month MAY	Dey Year 25 2000	2:19 PM
	/Medical	4a Facility Name (If not institution, give stre			4b. City, Town, or Location of De		
1	Examiner	OLD FREDERICK ROAD			HUGHESVILLE	CHARLES	
	Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last bir	thday) If Under 1 Year			thplace (State or Foreign
	Director	427-94-4891 1□ M	52 52	Yrs. Months Days	Hours Min. (Month, Aug 1	L9 1947	PA PA
pasha	show the state of	10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limits
Me.	octo	MD Calvert	Hur	tingtown			1 ☐ Yes 2HOXNo
4	Direct Di	10e. Streef and Number		10f. Zip Code		10g. Citizen of What Co	ountry?
4	23.	2221 Kings Landi	ng Road Wes Decedent Ever in U,S.	206		U.S.A.	riana Indian
and 21215-0020	position: Tages I struct as should be mad within 72 mouts ener deern with the weryten began and the left hand Mahriel Hydrone.  Important: If item 27 is marked other than "natural", or frame 23s or 28s4 show any injury or other traumatic event, the Medical Examinar must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Detes:	If Yes, specify Cub	lispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.) Specify:	Specify:	
0200-61212	ted for	15. Decedent's Educati	ion 16a.	Decedent's Usuei Occup (Give kind of work done life. DO NOT use retire	eation	16b. Kind of Business	
7	tel Hygiene. d other than "naturi avent, the Medical	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	d)		
7	Hygler the Co.	an Eshadaha di Maran Maran Adidaha da ah	2 X-	Ray Technic		Hospita	al
and a	Mentel H arked out	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Midd		
Maryland	marke matic	Charles O. Moi		Mailing Address (Street	Marion end Number or Rurel Route Nur		Leman Zio Code)
	trau	Mr. James R. Monn			y Green, Virgin		
e j	of Hee	20a. Method of Disposition	20b. Placa o	Disposition (Neme of ry, cremetory or other ple	Date	20c. Location - City or	
Pare	iry or	1 ☐ Burial 2X Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	loval from State	rematory	May 27 2000	Clinton,	MD
Sattimore,	Departra Importa any infu	21. Signature of Fether's Service Licegree	1	22. Name and Addre	ss of Facility Lee Fune	eral Home Cal	
		23a. Pert1. Enter the disease, or complicat shock, or heert failure. List only one of	ions that caused the death. Do	8125 Sout	hern Maryland E	arrest.	MD 20736 Approximete
E	/Medical examiner	Immediate Cause (Final disease or condition resulting in death)	MUUTIPUS ?	twomes consequence of):			
6876U,	physician and is the buriel-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		consequence of):		V = SY	
		resulting In death) Last		sivin=im/			
ם פּ	he att	Part II. Other eignificant conditions contrib	outing to death but not resulting in	n the underlying cause gi	ven in Part I. 23b. D	ld tobacco uee contribut	e to the cause of death?
DIVISION OF VITAL RECORDS, P.O. BOX	the hes been signed by the attending page 2 should be detached for use.					□ Yes 2 □ No 3 □ F	robably 40 Inknown
ds,	d by			The Print	24a. W	as en autopsy 24b.	Were autopsy findings
OS E	shour shoul				pe	erformed?	available prior to completion of cause of death?
D g	certificate hes rector, page 2				11	Yes 2 No	1 Yes 2 No
[ a	ertificati ector, pu Be C	25. Wes case referred to medical			26. Place of Death (Check on		18.68 28.10
	al direct	examiner? 1 X Yes 2 No	pital: 1 ☐ Inpatient 2 ☐ ER/Ou	stpatient 3 DOA Oth			ecity) SCENE
0 6	heral neral	27. Menner of Death 1 □ Netural 5 □ Pending		Time of 28c. Inju		be how injury occurred	
SIO	or: At	2 Accident investigation	5-25-00 2:1	4 P M 10	Yes 2000 DEINS	L OFUSR IMPE	
	as after death all Director: After to led in by the funera  Certification:	3 Suicide 6 Could not be determined	<ol> <li>Piaca of injury - At home, fa building, etc. (Specify)</li> </ol>			n (Street end Number or F Town, Stete)	
- lest	O D D D	29a. Certifier 1 Certifying Physici	ROPIN	1		¢ PLT 381 OHDO	
H P	in 24 hours he Funer pletely fill edical		<ul> <li>an: To the best of my knowledge</li> <li>On the basis of examination an and manner stated.</li> </ul>				
d of	within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page:  Medical Certification: To Be Com	29b. Signature and fitle of certifier	and a	29c. Licens	se number	29d. Date signed (Mon	th, Dey, Year)
	2. 0	1 auntal ho	Male	0.0	.M.E.	MAY 26, 2	000
		30, Neme and address of person who comp	pleted cause of death (Item 23a)		orloio	MAI 20, 2	000
	1	NAMA ALAMA	1/005. 140	111 -			
20	/	31. Date filed (Month, Day, Year)	32. Registrer's Signeture	III Penn St	reet, Baltimon	e, Mary Land	21201

DHMH 16 Rev 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 31, Day 000 Dulcie Teeter Randall May 550 A.M. 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street and number) 4c. County of Deeth Asbury- Solomons Health Care Center Solomons Calvert If Under 1 Year Months Days 8. Date of Birth (Month, Dey, Jan 15 Birthpiace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1921 1□M 2√2F 79 Jan Texas 24 1758 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11750 Asbury Circle 20688 United States 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11 Maritai Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify.white 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 18b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl E. Teeter Clara Katrina Staton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80906 80906 Electra Dr. S. Colorado Springs Col 19a. Informant's Name/Relationship (Type, Print) Richard L. Randallson 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Metropolitaina Funeral'service 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home PA LOC 4405 Broomes Is. Rd. Port Republic, MD 206 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) unk colon cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 No 1 TYes 2 TNo 1 Yes 25. Was cese referred to medical 26. Place of Death (Check only one) examiner's 1□ Yes 2₽ No Other: Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours after Department of Haalth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or her any injury or other traument.

Saltimore, Maryland 21215-0020

with the Maryland

death

Examiner Physician/Medical tha 60 USB detached þ Completed Be 2 Certification:

lcian and bunal-trans physician been signed by should be detac paga 2 certificata this funaral After death.

The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: after death 24 hours a To the Hosp within 24 hos To the Fune completely fi

State

Registrar

Taredio MD 29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D 47610

Excertifying Phyeician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and menner es stated

1 Yes 2 No

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) May 31, 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

David J. Tardio MD Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

1 Naturai

2 Accident

3 Suicide

29a. Certifier

Medical

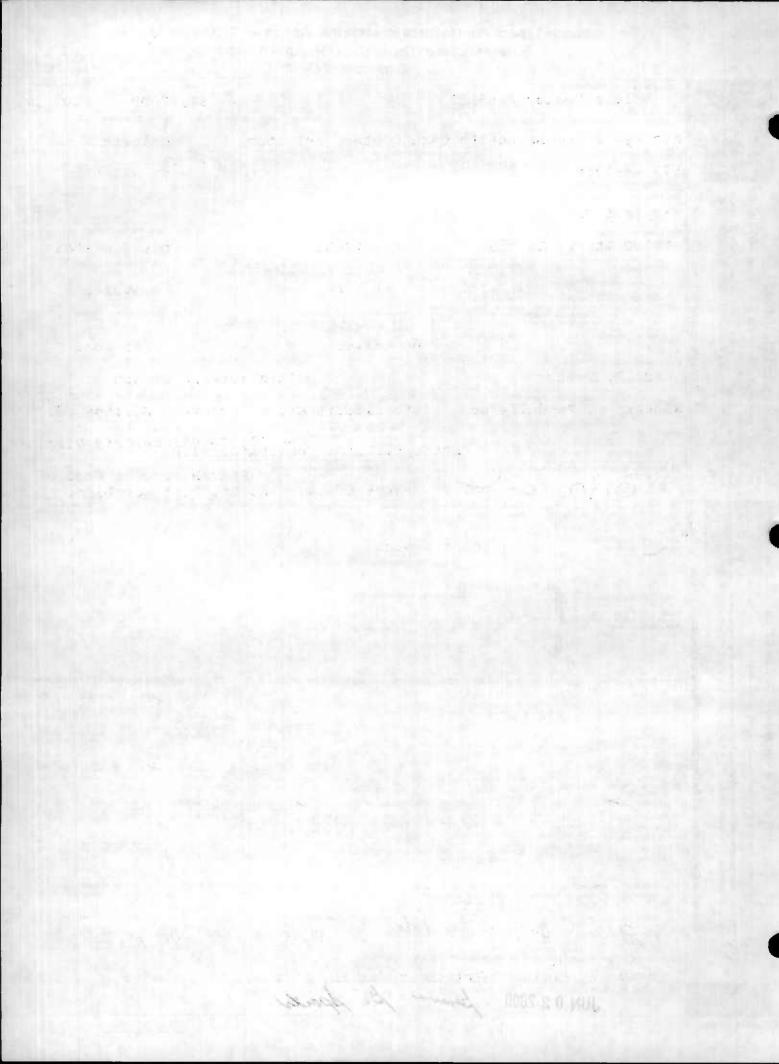
4 Homicide

5 Pending

investigation

6 Could not be determined

32. Registrar's Signeture JUN 0 2 2000



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Blanche 31, 2000 Louise May 9:10 p.m. 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Calvert County Nursing Center Prince Frederick Calvert. 8. Deta of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 ₩ F 81 577 36 6783 Vrs Aug. 8, 1918 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits Calvert Prince Frederick 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 85 Hospital Road 20678 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Wes Decedent Evar in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried white 1 ☐ Yes 2 1 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) factory worker Glass Company 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Annie Addie Armiger John Wesley Wilkerson 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

PO Box 1076, Eleanor B. King (sister) Prince Frederick, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Lower Marlboro UM Church 6-3-00 4 ☐ Donation 5 ☐ Other (Specify) Owings, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Rausch Funeral Home, Owings, MD 20736

234. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line.

Condiac

**Physician** /Medical Examiner

ettending physician and for use as the burial-transit

signed by the

certificate

i Hospital or Attending Physicien: 24 hours after death.
Funeral Director: After this certifica etely filled in by the lunaral director, p

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

pemit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show with Injury or other treumatic event, the Wadies Examiner must be notified at enes.

Baltimore, Maryland 21215-0020

**Physician** 

/Medical

Examiner

10a. Stete

Director

Funeral

à

Be

Physician/Medical Examiner

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Completed

Be

Medical Certification: To

MD

**Funeral** 

Director

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediete Cause (Final disease or condition resulting in deeth)

·	Due to (or as a consequence of):
b	Maloutritia
	Due to (or as a consequence of):
c	End Stage CHF  Due to (otes a consequence of):
	Due to (of e) a consequence of):
d	CAD SP CABG

Cacherin

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Renal

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 Yes 2 No

06-02-00

24a. Wes an autopsy performed? 1 ☐ Yes 2 12 No 24b. Were autopsy findings sveilable prior to completion of cause of deeth? 1 ☐ Yes 25 No

Approximete Intervel Between Onset end Deeth

examiner?				26. Place of Der	eth (Check only one)	
1 Yes 2 No	Hospitei: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA	Other: 4 Nursing I	lome 5 Residence	6 □Other (Specify)
27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Dete of Injury (Month, Day Year)	28b. Time of tnjury	28c.	Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred

3 Suicide 6 Could not be determined Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

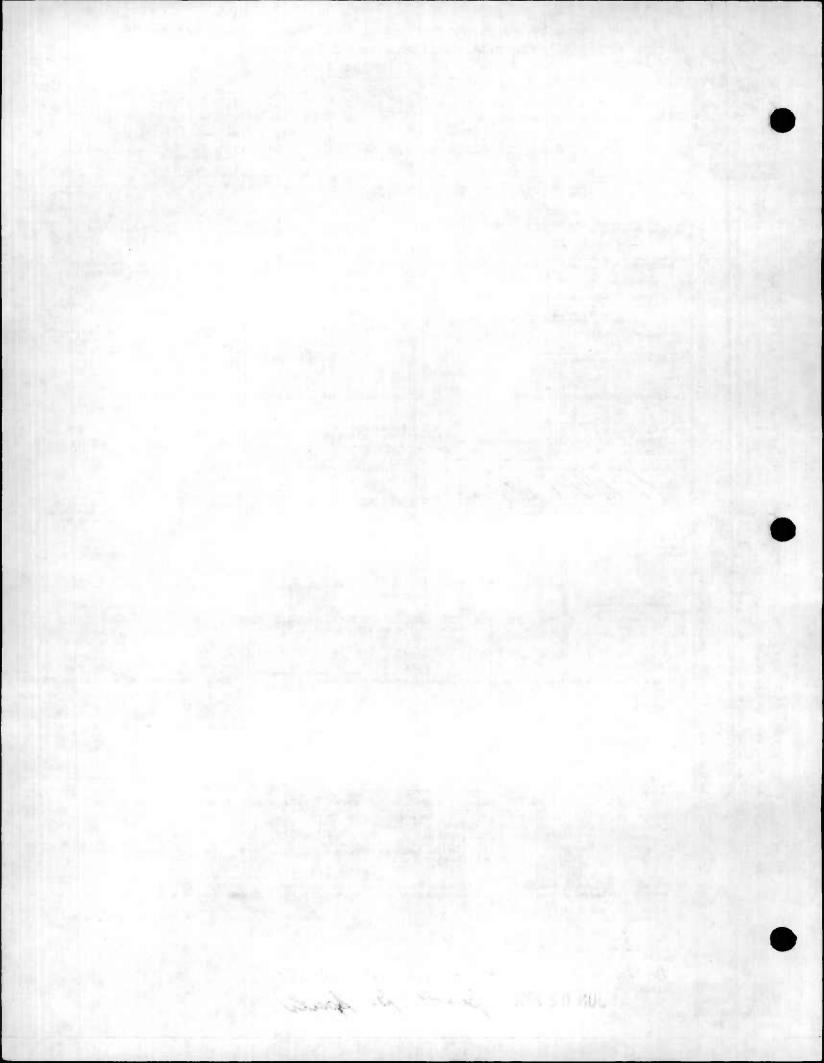
MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SKAL m.D. RINCE FREJERICK

State Registrar

8

50290



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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				Ce	rtifica	te of	Death			Reg. No.	00	100	00
ician	Decedent's Name (First, Middle	, Last)							2. Date of De Month	Day	Year		a of Death
dical	George Robert	-								1	2000		2:15
niner	4a Facility Name (If not institution,		mber)						cation of Deat		County of De	ath	
	Union Hospital  5. Social Security Number	6. Sex	7. Age (In yrs.	last histoday	If Unde	er 1 Year	Elkto		9 Date of Bi		Cecil	idhalass /Cu	to as Famina
	302-16-1602 Usual Residence of Decedent	1₽M 2□F	75	Yrs.	Months		Hours	Min.	8. Dete of Bi (Month, Di OCT 14	, 192	(	Country)	ate or Foreign
-	10a. State 10b. County		10c. Ci	ty, Town or Le	ocation							10d. Insid	le City Limits
× -	Maryland Cec:	11	E	lkton	101.7	ip Code			1	10a Chia	en ol Whet (		Yas 2XNo
a Dir	67 Charles Stre	et				1921					ed Sta		
by Fur	11. Marital Status  1 Never Married 2 X Marrie  3 Widowed 4 Divorced	Armed F	2 No WO	27.4	Was Dece II Yes, spo 1 Yes		lispanic Orig an, Mexican, Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		4. Race - An Bleck, Wh Specify: V		n,
eted	15. Decedent' (Specify only highest	s Education grade completed		(Give	dent's Usi	ork done	during most	of worki	ing	16b. Kind	d of Busines	s/Industry	
Be Completed	Elementary/Secondary (0-12)	T	1-4or 5+)	life.	ety E	use <i>retire</i>	3)				rance		
ŏ	17. Father's Name (First, Middle, L	.ast)		Sale	ety E	лутп		r's Name	(First, Middle	Indus , Maiden S			
0	Howard O'Lee Sh	arp					Lora	a Ma	e Wood				
-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ing Addres	s (Street	end Numbe	or or Rura	I Route Numb	er, City or	Town, State	, Zip Code)	
	Lauren H. Freng	/Daughter					eet, E	lkto	n, Mary	land	21921		
1	20a. Method of Disposition  1 Burial 2 Cremetion  4 Donation 5 Other (Sp		State	Place of Disponentery, cre st Nott	metory or	other pla			une 3, 2000			or Town, State	
	21. Signature of Funeral Service L	icensee	500	H:	2 Name a icks 03 W.	Home Stoc	for kton S	Fune Stree	rals, l	P.A. ton, M	aryla	nd 219	21
	23a. Pert1. Enter the disease, or a shock, or heart leiture. List of Immediate Cause (Finat disease or condition resulting in death)	only one cause on	each line.										Between and Death
2		0	Due to (i	or as e conse	quence of	):						1	
xamir	Sequentially lis1 conditions, if any, leading to immediate	b		or as a conse	quence of)	):	77						1 3/77
2	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (c	or as a consec	quence of)	:							Ties
3		d											
Physician	Part It. Other significant condition	s contributing to d	eath but not res	sulting in the u	underlying	cause giv	en in Pert t.		23b. Did	1obacco u	ae contribu	rte 10 1he cau	see of death?
by Ph	Polyneurop	athy		2 2					1 🗆	Yea 2	]No 3□	Probably	42 Unknown
Completed t				11,9						an eutops ormed?	24t	were autor available procompletion of death?	rior to
Eo									10	Yes 2	No	1 🗆 Yes	2 No
	25. Was cese referred to medical						26. Place	ol Deeth	(Check only	one)			
T0	axaminer? 1 ☐ Yes 2 ☑ No	Hospitat:	Inpatient 2	ER/Outpatie	nt 3 D	OA Oth	ier: 4 Nui	rsing Ho	me 5 Res	idence 6	Other (St	pecify)	
	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		of Injury oth, Day Year)	28b. Time o Injury	of M	28c. Injur Wor 1 🗆	yat k? Yes 2 □ M		28d. Describe	how injury	occurred		
(EE )	3 Suicide 6 Could no	ned 288. Plac	e of Injury - At h ing, etc. (Speci	ome, farm, st	reet, fecto	ry, office			28f. Location ( City or To	(Street and wn, Stete)	Number or	Rural Route	Number,
Certifica	4 ☐ Homicide determin	1		wiedne deet									- 4.5
dical Certification:	4 ☐ Hornicios  29a. Certifier 1 ☐ Certifying	Physician: To the xaminer: On the band man			vestigatio	n, in my o	pinion, deet	th occurr	ed at the time,	dete end p	plece, and d	ue to the cau	se(s)
edical	29a. Certifier 1 Certifying (Check only 2 Medical E	xaminer: On the b	asis of examina				e number	in occurr	ed at the time,			onth, Dey, Yea	
Medical	29a. Certifier   1 Certifying   Check only one)   2   Medical E	naminer: On the band man	easis of examina	1D	29	c. Licens			ed at the time,	29d. Date		nth, Dey, Yea	
Wedical VA	29a. Certifier (Check only and) 29b. Signature and title of certifier	Martelumbo completed cau	esis of examination stated.	n 23a) (Type,	Print)	9c. Licens	se number	75		29d. Date	signed (Mo 28/0)	nth, Day, Yea	ar)

DHMH 16 Rev 6/95

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Year **Physician** David Richard Steady 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Peath 4c. County of Death **Examiner** Union Hospital of Cecil E1kton Cecil County If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 180 M 2□ F Yrs. Director 009-34-1827 April 3,1945 Vermont Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or floms 23a or 28a-f show traumetic event, the Medical Examples must be notified at 1 ☐ Yes 2 ☐ No Director Maryland | Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 164 Danford Drive 21921 United States Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

1 ☑ Yes 2 □ No 06/1979
If Yes, Give
Year or Detes: 09/1991 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Meritei Stetus filed within 72 hours after 1 ☐ Never Merried 2 X Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 Master Sergeant United States Army peamit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event ables. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Francelia Agnes Steady unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 164 Danford Drive, Elkton, Maryland 21921 Ethel M. Steady / Spouse 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 N Burial 2 Cremetion 3 Removal from Stete June 5, 4 ☐ Donation 5 ☐ Other (Specify) North East Methodist Cemetery 2000 North East, Maryland 21. Signatural Fungual Service Licensee 22. Name and Address of Fecility
Crouch Funeral Home, 127 South Main Street Well. 4. Word North East, Maryland 21901 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical · Acute Myocardial Infarction Examiner Due to (or es a consequence of): ASCUD Examir Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that intleted events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or es a consequence of) å Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? High Blood Pressure, Non in sulin Dependent Dy 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Wes an eutopsy performed? Completed completion of cause of death? 2/2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 ž To the Mospital or Attending Pt within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. 29e. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) Jarkes, June 1, 2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Union Hospital Furkas 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature Registrar

ORIGINAL

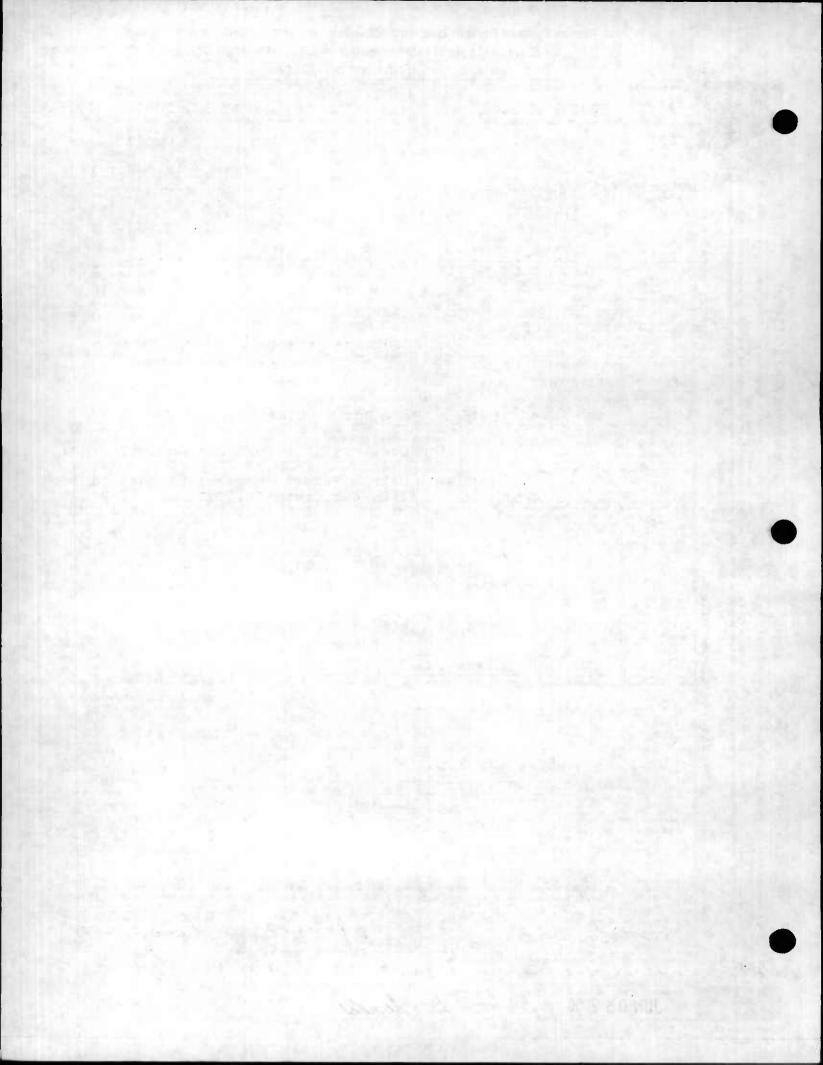
DHMH 16 Rev 6/95

Carley

# Please Type or Print in Black indelibie ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 19068

						Certificate o	of Death	1	R	leg. No.			
		1. Decedent's Nar	ne (First, Middle	, Last)				2.	Date of Dee			3. Time of Death	
	Physician	JAMES	DEEC	E CHODM					Month	Day	Year	2 25	
	_/Medical		REES.	E SHORT  give street and num			4h City To	own, or Locat	IAY 3			2:25pm	
	Examiner				Der)				non or beauti	4c. County	OI DeellI		
			ast Ma				Ceci			Cec	i1		
	• Funeral	5. Social Security	Number	6. Sex 7	. Age (In yrs. last birth	Months Da		Min. 8.	Dele of Birth (Month, Dey	Year)	9. Birthp	place (Stete or Forei	gn
	Director	195-05	-5750	HOLM 2LIF	86 Y	8.	,	J	une 9	1913	Mar	yland	
	0	Usual Residence											
	arytar abow d.et	10a. Slate	10b. County		10c. City, Town	or Location					1	10d. Inside City Limi	ts
	Man Man	MD	Ceci	i 1	Cecilt	on						1 <b>3</b> Yes 2 □ N	lo
	or 28a-f sh be notified.	10e. Street and N	umber			10f. Zip Cod	0		1	log. Citizen of V	Vhat Cour	ntry?	
	\$ 5 M			4									
	r Rems 23a siner must b	234 E	ast Mai		tion Employee	219		d=i=0 (0===i4	. Was as Ma	U.S.A.	A Amaria	can Indian,	
	New	11. Marital Sletus		Armed Fore		<ol><li>Wes Decedent of It Yes, specify C</li></ol>	uben, Mexica	in, Puerto Ric	en, etc.)		k, White,		
20			rried  Merri	ed 1.X Yes :		1 □ Yes 2001	No Specify:			Specify	W	nite	
8	ens.		4 Divorced	Year or Da	tes: WWII					,,,,,	***	11 00	
3	ad within 72 ho yglene. Ar than 'natur f, the Medical.	(So	15. Decedent	s Education t grade completed)	16a. D	ecedent's Usuel Oc	cupetion	st of working		16b. Kind of Bu	siness/în	dustry	
2	4 . s 4 0	Elementery/Sec		College (1-	4or 5+)	Give kind of work do ife. DO NOT use re	tired)						
2	FEET S	12			I	nsurance	Brok	er		Insu	ranc	e	
D	and the state of t		(First, Middle, L	ast)			18. Moth	er's Name (F	irst, Middle,	Maiden Sumam	9)		
ar			Hall S	hort			Vor	tie W	Joo 1 1 1	chan			
2	d Men d Men meric meric	19a. Informani's f			106	Mailing Address (Str.					State 7is	Code	_
Maryland 21215-0020	12 sh	Louise										, 0000)	
	m 27 m 27 her tr					.O. Box				D. 219			
ō	If its	20e. Method of Di		3 □Removal from S	cemetery.	Disposition (Name of cremetory or other	place)		Date	20c. Location -	City or 10	own, State	
Ē			5 Other (Sp		Zion	Cemetery	Y	6/:	3/00	Ceci1	ton	, MD.	
Baltimore,	nit. Pa sartmer cortant injury	21. Signature of F	uneral Stryica L	icense		22. Name and Ad	dress of Fecili	lity			17379	Trade-	
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		1	1.	- Dec		118 West	Cros	ss St	. Gal	ena, M	D.	21635	
- 00		shock or he	all lasure. List of	only one cause on ee	used the death. Do no	t enter the mode of	dying, such as	s cardiac or re	espiratory en	rest,		Approximete Intervel Between	
	Physician	/										Onset and Death	
	/Medical	Immediate Ceuse disease or condit	ion	0	la pu to							7days	
	Examiner	resulting in death	)	a	Due to (or as e co	ensequence of):	11000		10.5			1-1-1	
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8	certificate be ding physicie ise as the bu	resulting in death	Lasf	_	Due to (or as e co	nsequence or):					1		
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Bo	death of attended for us	B			1 2 2								
	the s	Part II. Other sign	ificant condition	ns contributing to dea	ath but not resulting In I	he underlying cause	given in Part	t.	23b. Did t	obacco uss co	ntributs t	o the cause of deat	h?
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	v requires thet the been signed by should be detected by Physical	Cong.	estive	neari	failure								
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00	shot shot	CAL							perfor	med?	CC	mpletion of cause	
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=	The sate h	care	nic n	enal x	allune				1 U Y	es 24 No	11	Yes 200 No	
of Vital Records,	Physician: The I this certificate harral director, page		rred to medical				26. Plac	e of Death (C	Check only o	ne)			
2	nis ce I dire		No	Hospital: 1 ☐ In	patient 2 ER/Outp	atient 3 DOA	Other: 4 N	lursing Home	5 Resid	ence 6 Oth	er (Speci	fy)	
0	ding Phys h. After this funeral d	27. Menner of Dea		28a. Date of	injury 28b. Tir	ne of 28c. i	njury at Work?	280	d. Describe h	ow injury occur	red		
0	the Att	1 Natural 2 Accident	5 Pending investig		n, Dey Year) Inj		Yes 2	No					
Division	rs after death.  In Director: After t ied in by the funers  Certification:	3 Suicide	6 ☐ Could n		of Injury - At home, fam	n street factory offi	ce	28f	Location (S	Street and Numb	er or Run	al Route Number,	
2	Olres in b	4  Homicide	determi	buildin	g, etc. (Specify)	n, oncon, ractory, on			City or Tow				
-	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1					4.1.4		- 4 - 1	4.4				
	n 24 hound n 24 hound he Funer pletely fill	29e. Certifier (Check only		xaminer: On the bas	est of my knowledge, as of examination and/								
	To the Hospital within 24 hours To the Funeral completely filled		4.04	and manne	er stated.				1	201 5 1	4 (3.4)	Own Warns	
	To the Com	29b. Signature an		1		29c. Lic	ense number	779		29d. Dale signe Tunk			
	.1	VR	00.0	Main									
	20+1 VA	30. Name and add	Iress of person v	who completed cause	of death (Item 23a) (T	ype, Print)	,	n	/	4/11	in	1 7 191	7
	207	W. Bru	ce 060	nghain,	of death (Item 23a) (T	15. Bo	remio	a Hue.	, Le	cittar	1		
	State	31. Date filed (Mo	nth, Day, Year)		gistrar's Signature								
	State Registrar	JUN		Gener	~ 4	Son V.							



1. Decedent's Name (First, Middla, Last)

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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00	- 1	9	0	-
UU	- 1	4	11	3
		4	V	V

2. Date of Death

MAY 28, 2000

9

3. Tima of Death

4	/Medical	Michael Curtis S					MAY	27	2000	16:46 PM
	Examiner	And the state of t				4b. City, Town, or L	ocation of Death	4c. County		
	THE STATE OF	ROUTE 273 NEAR G			If Under 1 Year	If Under 24 Hrs.	La Bara (Bid	CE	CIL	
	Funeral Director	546-08-5724	Sex   7. Age (In yrs   33	. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 23	Year) , 1967	Calif	ace (State or Foreign ry) fornia
	P	Usual Residence of Decedent  10a, State 10b, County	10c. C	ity, Town or Loc	ation				10	d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show mast be notified at			vark			143			1 ☐ Yes 2 🕅 No
	ith th	10e. Street and Number			10f. Zip Code		10	og. Citizan of W	/hat Count	ry?
	ath w				19702			nited S		
20	5 28 3		12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If	/as Decedent of l Yes, specify Cub ☐ Yes 2 ☐ No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- America k, White, e	tc.
Maryland 21215-0020	"natural", or no call frame	3 Widowed 4 Divorced	Year or Dates:	16a Dagada	ent's Usual Occu	antina		16b. Kind of Bu	Whit	
5	"natur edical	15. Decedent's E (Specify only highest gr	ade completed)	(Give k	rind of work done O NOT use retire	during most of work	dng	IOD. KING OF BU	31110.53711101	istry
12	be filed within 72 ho tal Hydlene. d other than "nature event, or the cell.	Elamantary/Secondary (0-12)	College (1-4or 5+)			Web Page I	Designer	Inter	net /	Computer
0	be filed that Hygh d other event, p	17. Father's Name (First, Middle, Las	)	perr en	приоуси	18. Mother's Nam				Compacer
au	Mental Mental arked o atic ev	Harway W. Ciackar				Mildrod	II Dolon	0.11		
2	should be and Mental marked our urmatic ev	Harvey W. Siecker  19a. Informant's Name/Relationship		19b. Mailing	Address (Stree	Mildred tand Number or Ru			State, Zip (	Code) OFO/F
Š	W = = =				Telephone Co.					93943
a)	1 and Heelth em 27 other tu	Mildred U. Delane 20a. Method of Disposition		Place of Dispos	ition (Name of	chool Str	Date 2	SS_VALLE		
<u></u>	Pages nent of int: If its iry or o	1 ☐ Burial 2 ☐ Cremation 3 [			atory or other pla	l,		West Ch		•
Baltimore,		4 Donation 5 Other (Soap)			is Co.			Pennsy1		
Ra	pemit. Pag Department Important: I any Injury o	21. Signature of Funeral Service Uto	mel			ess of Facility neral Hom t, Maryla		outh Ma	in St	reet,
		23d. Part1. Enter the disease, or conshock, or heart failura. List only	plications that caused the dea					est,	1	Approximate Interval Batween
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Multiple	In u	uence of):				1	Onset and Death
	executed in end haltransit		b	or as a consequ		-74-9	11.13		1	
Ď,			500 10 1	or as a consequ	renice ory.					
9/89	4 54 5	that initiated events resulting in death) Last	Due to (	or as a consequ	ence of):					
Box	eth certifica ettending planter use es t		d							
		Part II. Other significant conditions	contributing to death but not ra	sulting in the un	derlying cause gi	iven in Part I.	23b. Dld to	bacco use cor	atribute to	the cause of death?
J.	d by the set ach						1 🗆 Y	2 2 No	3 Prob	ably 4 Unknown
ds,	signe d be d						040 11/00 0		24h Wa	ra autopsy findings
Vital Records,	The law requires that the sate has been signed by the page 2 should be detach.						24a. Was a perform	ned?	ava	illable prior to nplation of cause leath?
r	The I						paxo	s 2 No	1/8	es 2□ No
<u> </u>	entifica ector, Be C	25. Was case referred to medical				26. Placa of Dea	th (Chack only on	e)		
	Physician: rthis certific ral director,	examiner?	Hospital:	☐ ER/Outpatient	3 DOA	her: 4 Nursing H	ome 5 Reside	nce 6 Oth	er (Specify	SCENE
ion of	D 0 2		28a. Date of Injury (Month, Day Year) 5 - Z 7 - O	28b. Tima of Injury	28c. Inju Wo		28d. Dascribe ho	w injury occurr	ed	
DIVISION	tal or Attending P is after death.  al Director: After tied in by the funeric Certification:	3 Suicide 6 Could not l 4 Homicide detarmined	OB Diam of Injury At I	nome, farm, stre	et, factory, office			, Stata)	er or Rural 2730 (	Route Number. Rd Gallaher Rd
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur Medical Certification	29a. Cartifier 1 Certifying Pl	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owiedga, daath	occurred at tha t		and dua to tha ca			
	To the comple	29b. Signature and title of certifier	001		29c. Lican	sa number	2	9d. Date signer	d (Month, L	Day, Year)

State Registrar

Dennis J. Chutero 31. Date filed (Month, Day, Year)

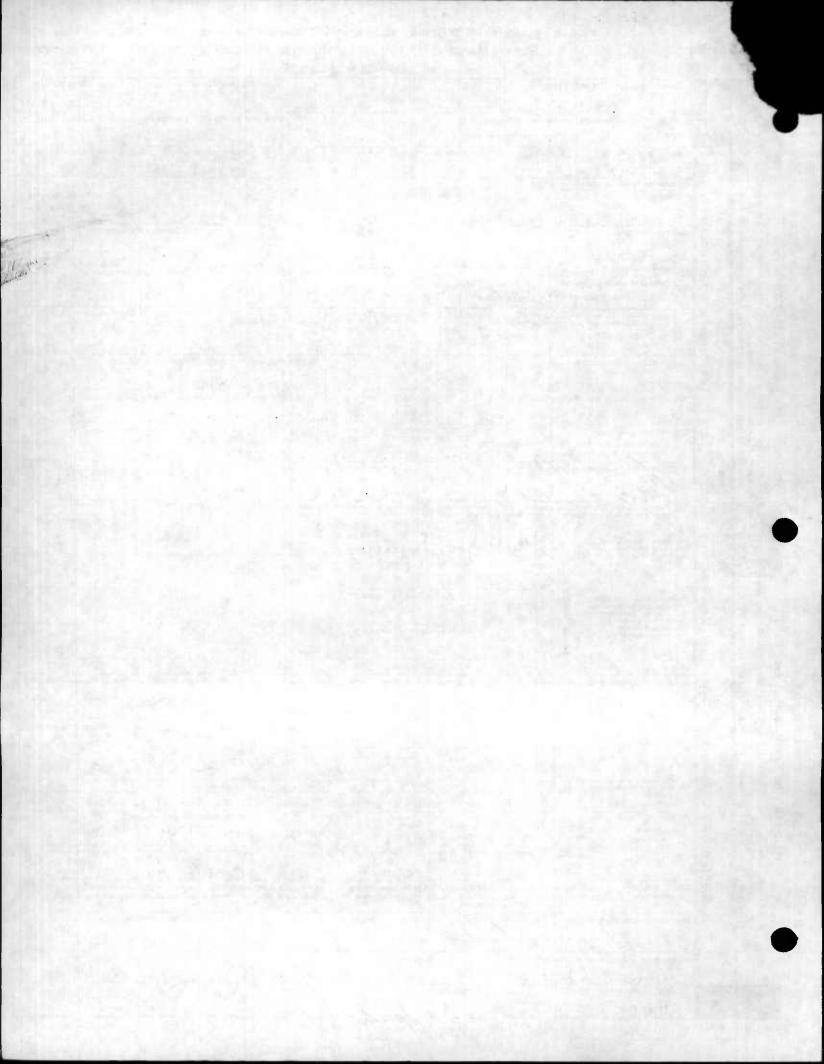
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O.C.M.E.

Penn Street, Baltimore, Maryland 21201

**DHMH 16 Ray 6/95** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Day Year Month Smith Culler Jesse 21:45 2000 June 2 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 24 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 12 M 2 F Days 173-03-2985 80 Yrs Aug. Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes ZE No Smithsburg Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

21783

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Neme end Address of Fecility

Davis Funeral Home

Inspector

20b. Place of Disposition (Name of cemetery, cremetory or other place)

Ringgold Cemetery

Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)

U.S.A.

14. Race - American Indien, Bleck, White, etc.

Specify: White

20c. Location - City or Town, Stete

Ringgold, Md.

Hageistown. MD. 21

12525 Bradbury Ave.

16b. Kind of Business/Industry

Truck Co.

18. Mother's Neme (First, Middle, Maiden Surname)

June 7.

2000

Mary E. Culler

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 13113 Greensburg Rd. Smithsburg, Md. 21783

death with the Maryland Items 23s or 28s-f ner must be notifie permit. Pages 1 and 2 should be filed within 72 hours ather of Department of Health and Montal Hyglene. Important if Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examinat aniolo. Baltimore, Maryland 21215-0020

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

á

Completed

80

Md.

11. Marital Status

13113 Greensburg

15. Decedent's Education (Specify only highest grade completed)

1 Never Merried 2 Merried

3 ☐ Widowed 4 ☐ Divorced

Elementery/Secondary (0-12)

17. Fether's Neme (First, Middle, Last)

Fauvette W. Smith

Signature of Funeral Service Lice

19a. Intorment's Neme/Relationship (Type, Print)

A Donetion 5 Other (Specify)

John M. Smith

20a Method of Disposition

Rd.

Wes Decedent Ever in U,S. Armed Forces?

College (1-4or 5+)

(wife)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YANPING YU, MO

JUN 0 5 2000

31. Date tiled (Month, Day, Year)

21931

32. Registrar's Signature

1 Ves 2 No
WYes, Give
Year or Dates: 41-46

**Funeral** 

Director

**Physician** /Medical Examiner

sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Coller Smith Division of Vital Records. lesse ( To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afti complately filled in by the fun

snock, or neart tailure. List only	one cause on each line.	the mode of dying, such es card	Smithsburg, Md iac or respiratory arrest.	Approximata Interval Between Onset and Death
Immediate Cause (Finat disease or condition	a. failure to the	rive.		
resulting in death)	Due to (or as a consequence of the consequence of t	ence or): failure		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Congestive hen Due to (or as a consequence.  End Stall re Due to (or as a consequence.	ence of:	e on dialysis	5
that initiated events resulting in death) Last	d. or cute perito	ence of):  \identify	V	
The state of the s	contributing to death but not resulting in the unc $arrho$		23b. Dld tobacco use con 1 ☐ Yes 2 ☐ No	ntribute to the cause of death?
	obstructive lung	disease	24a. Wes en autopsy performed?	24b. Were autopsy tindings evailable prior to
Curoniz			-	completion of cause of death?
		<u></u>	1 Yes 2 No	of death?
25. Wes case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of D	Death (Check only one)	of déath?
25. Wes case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1/ Netural 5 Pending investigation	Hospital: 1 Inpatient 2 ER/Outpatient  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	26. Place of D		of déath?  1   Yes 2   No  er (Specify)
25. Wes case referred to medical examiner?  1  Yes 2 No  27. Manper of Death   Netural 5  Pending	Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year)  28b. Time of Injury	26. Place of D  3 DOA Other: 4 Nursing  28c. Injury at Work?  M 1 Yes 2 No	Death (Check only one)  J Home 5 Residence 6 Oth	of déath?  1  Yes 2 No  er (Specify)
25. Wes case referred to medical examiner?  1 Yes 2 No  27. Manger of Death  1 Netural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying Pt	Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	26. Place of D  3 DOA Other: 4 Nursing  28c. Injury at Work?  M 1 Yes 2 No  et, fectory, office	Death (Check only one)  J Home 5 Residence 6 Oth  28d. Describe how injury occur  28f. Location (Street and Numb City or Town, Stete)	of death?  1  Yes 2 No  er (Specify)  red  per or Rural Route Number,

**DHMH 16 Rev 6/95** 

State

Registrar

Oak Hill

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Fay Desiderio Smeck lune 01, 2000 7:55 AM 4a. Facility Name (If not Institution, give straet and number) 4b. City, Town, or Location of Death 4c. County of Death Washington FANCHEY-Keedy HUrsinG Home Koonsboro If Undar 1 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Month, Day, July 19 9. Birthplace (State or Foreign Country) New York Days 1 M X F Months 88 080-16-2516 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits New York N.Y. New York 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 590 West End Ave. 10024 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home. Homemaker 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Surnama) Caroline Marino Salvatore Desiderio 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Judith E. Ferro (Daughter-in=Law) 6 Maple Ave. P.O. Box 156 Smithsburg, Md. 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 4 1 ☐ Burlal 2 X Cremetion 3 ☐ Removal from Stete 4 Donation 5 ☐ Other (Specify) Smithsburg Crematory 2000 Smithsburg, Md. 1. Signatura of Funeral Sarvice License 22. Name and Addrass of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Pert1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiec or raspiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximata Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) coming Antens Dire m Due to (or as a consequence of): timo relevative Due to (or as a consequanca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hinknown

Physician /Medical Examiner

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

TH

**Physician** 

/Medical

Examiner

Director

Funerai

þ

Completed

Be

2

Funeral

Director

or 28a-f

or items 23s

"natural",

marked other than

permit. Peges 1 end 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event ONGs.

Baltimore, Maryland 21215-0020

traumatic event, the Medical Examiner must be notified at

Examiner ettending physician for use as the buria by Physician/Medical signed by the e Be Completed has certificate tal or Attanding Physician: Tre after death.

al Director: After this certificatied in by the funeral director, pa

P

Certification:

Medical

1 Tyes 2 11 No

27. Menner of Death

1 BNatural

2 Accident

3 Suicide

4 Homicide

(Check only

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Last 25. Was cese referred to medical examinar?

24b. Wera autopsy findings available prior to 24a. Was an autopsy completion of causa of death? 1 Yas 2 1 NO 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Numbar or Rural Route Number, City or Town, Stete)

1 Confirming Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and dua to the cause(s) and manner steted.

29b. Signature and title of certifier CM states-

5 Pending Investigation

6 Could not be determined

29c. Licensa number 29d. Data signad (Month, Day, Year) JUNE 1, 2000 D(8019

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

MD 21740 DATTA, M.D. 334 MILL ST MAGERSTOWN 31. Date filed (Month, Day, Year) JUN 0 5 2000

Registrar

32. Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

24 hours a

To the I within 2

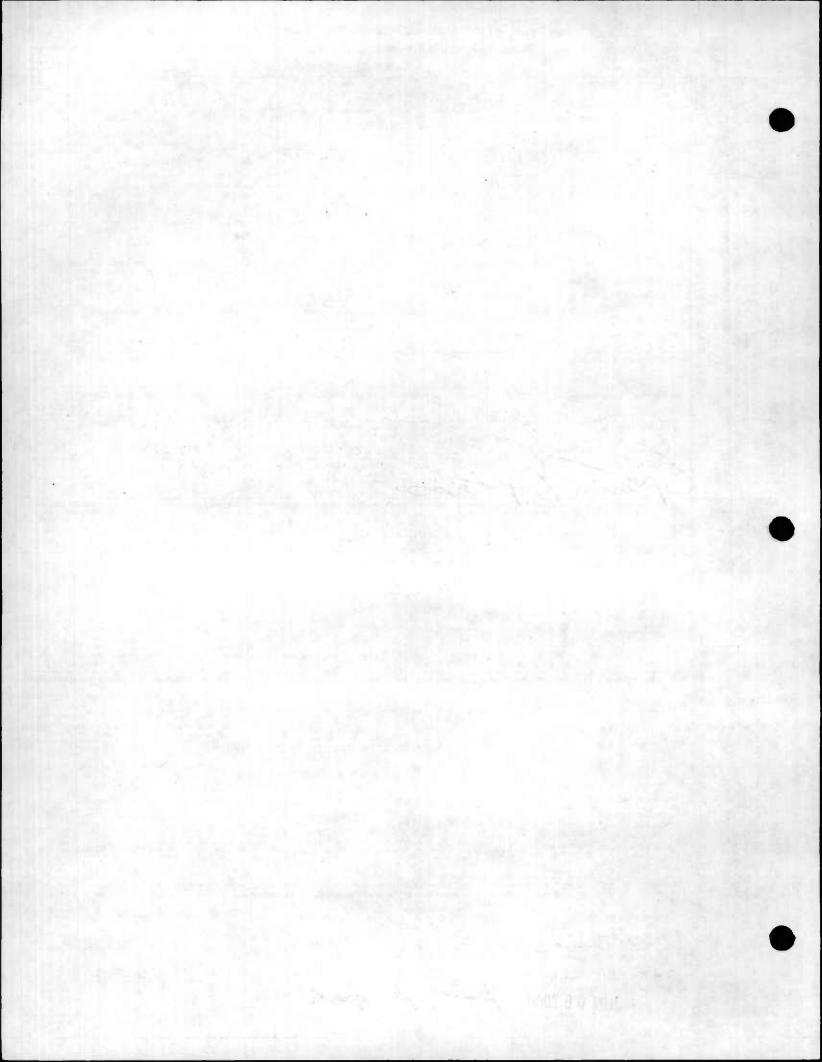
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month June **Physician** 2000 7:50 A.M. Frank Lexington Simpson /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11159 Baltimore National Pike Myersville Frederick H Under 24 Hrs. 8. Data of Birth 9. Birthplaca (Stata or Foraign Hours Min. March 37, 1926 North Carolina 5. Sociei Security Number 6. Sax If Undar 1 Year 7. Age (In yrs. last birthday) **Funeral** Months Days 100 M 20 F 242-26-8068 74 Director Usuel Rasidence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Md. Frederick Myersville 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ò 11159 Baltimore National Pike 21773 U.S.A. 'natural', or items 23s Funeral 12. Wes Decedent Evar in U.S.
Argied Forcas?
1 ☐ Yas 2 ☐ No
If Yes, Giva 41-46
Yaer or Datas. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Raca - Amarican Indian permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or then any Injury or other treumatic event, the second of the secon 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify. Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) Dept. Store Manager 17. Fathar's Nama (First, Middla, Last) 18 Mother's Name (First Middle Maiden Surgama) Be Pratt Frank Lexington Simpson Sr. Minnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, Cify or Town, Stata, Zip Coda) 11159 Baltimore National Pike Myersville, Md. (wife) Estella G. Simpson 20b. Piaca of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata June 3 1 Buriel 2 Cramation 3 Remova Ton Sta 4 Donation 5 Othar (Specify) Smithsburg Crematory Smithsburg, Md. 2000 23 Signature of Fineral Service Licen 22. Nama and Addrass of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Entar tha disassa, or complications that caused tha death. Do not entar the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Metastatic NON- Small Cell Carcinona Examiner Dua to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 42 hours state death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the bunkal transit Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disaasa or Injury that initiated events rasulting In death) Last Dua (or as a consequenca of): Box 68760, Physician/Medicai Dua to (or as a consequence of) Records, P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings availabla prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yas 2 No 1 Yes 2 No Division of Vital 25. Was casa ratarred to medicel 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 25 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 5 Pending invastigation Natural 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28e. Plece of Injury - At homa, larm, streat, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 29a. Certifier Tertifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated.

| Madical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titia of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 6-2-00 MO 51610 30. Name end eddrass of person who complated causa of death (Item 23s) (Type, Print) Michael A. Tolino M.D. Suite 21702 Taner 32. Registrer's Signatura 31. Data filed (Month, Day, Year)

JUN 06 2000 State Registrar



#### Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** Lillian 5,2000 Estelle /Medical Stagner Jun. 3:10 PM 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 8. Data of Birth (Month, Day, Year) If Under 1 Yas Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Hours Months 10 M 25 F Director 235-70-1040 Feb. 19, 1926 WV Usual Residence of Deceden 10a. Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits 1 Yas 2 No MD Washington Smithsburg Funeral Director 288-1 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? tems 23s or 23250 Leathers Road 21783 USA 12. Wes Decedant Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yas, Give X 1 Never Married 2 Married ĕ 1 ☐ Yas 2 ☐ No Specify: Specify: White þ 3. Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Hygiene. other than Elemantary/Secondery (0-12) Collega (1-4or 5+) Foundry worker Brass Foundry 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Sumama) Be Department of Health and Mental Important: If Item 27 is marked o 2 Thomas Sowers Clara Hough 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 23250 Leathers Rd. Smithsburg, Md. 21783 ce of Disposition (Nama of Data 20c, Location City or Town, State Raymond W. Stagner/ 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition 1 □XBurial 2 □ Cramation 3 □ Removal from State Pleasant View Mem. Gdns. 6/9/00 Martinsburg, W. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Neme end Addrass of Facility Signature of Funeral Sarvice Licensee Burner Trade Services 1037 Dual Place, Hagerstown, Md. 21740 Jurney 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intervel Between Onsat and Daath Physician Colitis nvienical Immediate Cause (Final seudonem branous disaasa or condition rasulting in death) **Examiner** Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to Immadiete causa. Entar Undarlying Cause (Disaase or injury that Initieted events rasulting In daath) Last Dua to (or as e consequenca of): Medical Certification: To Be Completed by Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to complation of causa of death? 2 12 No 1 ☐ Yes 2 ☐ No

Estelle To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Baltimore, Maryland 21215-0020

25. Was ca axamin 1 ☐ Ya		Hospital:	spital: 1 Department 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidanca						
	r of Death tural 5 Panding	28a. Deta of Injury (Month, Day Year)		28c. fnjury at Work?	28d. Describe how Injury occurred				
3 ☐ Su 4 ☐ Ho	uicida 6 Could not omicide determine		homa, farm, street, fact	ory, office	28f. Location (Street and Number or Rural Routa Number, City or Town, State)				

29b. Signetura and titla of cartifier

31. Data filed (Month, Day, Year)

JUN

29c. Licansa number 053273

29d. Data signad (Month, Day, Year) JUNE 2000

30. Name and address of parson who complated cause of death (Itam 23a) (Type, Print) Holtsdaw

2000

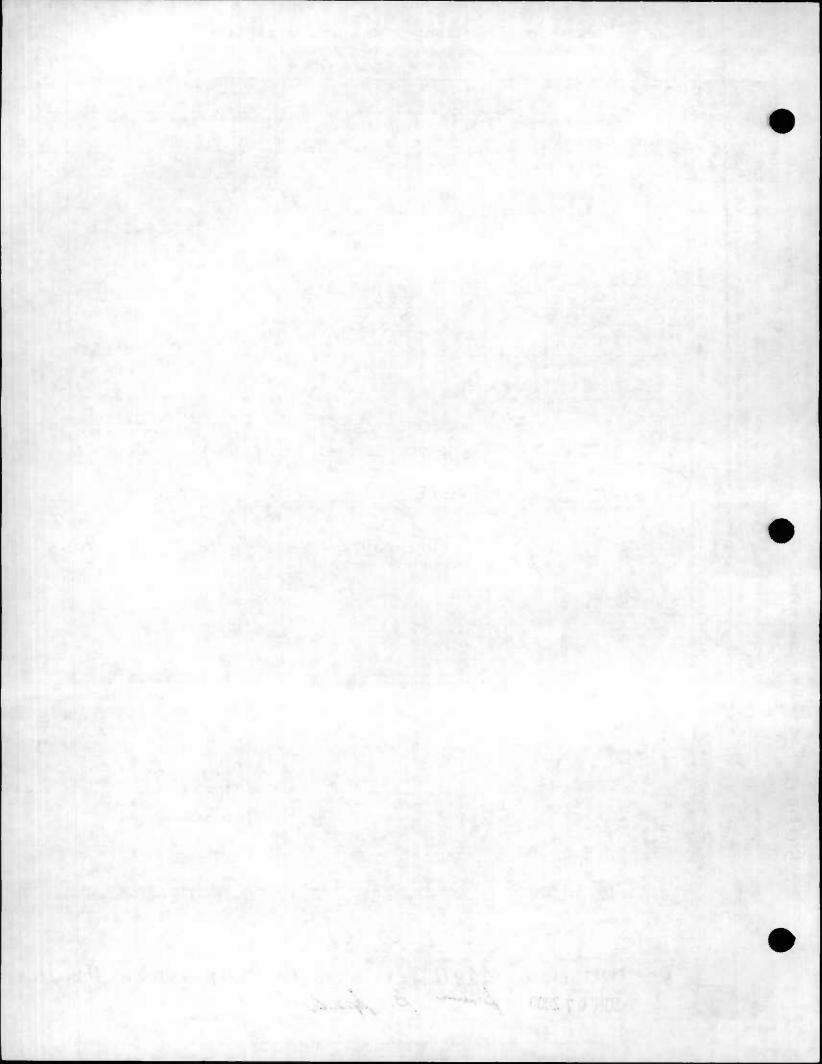
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32. Redistrar's Signatura

Blud Hagerstown

State Registrar



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Decedent's Neme (First, Middle, L.	ast)		Certificate of	Death	2. Date of D	eath	00	3. Time of Death
	Physic /Modi			SUSAN	T. ST	ERLING		May	Day 24	Year 2000	8:50 PM
	/Medi Examlı		4a. Facility Neme (If not institution, gi	ve street end number)			4b. City, Town, or	-		ty of Death	
1			26403 Asbury A				Crisfie			merse	t
	Funeral Director			Sax 7. Ag	na (In yrs. last bir 101	thday) If Undar 1 Yea Months Deys		8. Date of Bi (Month, D	irth ley, Yeer) 3, 1899	9. Birthp Cour Mar	place (Stete or Foreign htty) <b>yland</b>
	how		10e. State 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits
	r 28a-f show	ctor	Maryland Somer	rset		Crisfield	1				1 ☐ Yes 2 XNo
	ath with the 23a or 28	ral Dire	10e. Street and Number 26403 Asbury A	ve.		10f. Zip Code	21817		10g. Citizen of		ntry?
5-0020	72 hours after daath with the Maryland natural', or items 23a or 28a-f show ical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☎ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cut		pacify Yes or N o Ricen, etc.)		ice - Americack, While,	etc.
5-0	72 hours "natural",	eted	15. Decedent's E (Specify only highest gr	ducetion rade completed)	16a.	Decedent's Usual Occu (Give kind of work done	pation during most of wor	kina	16b. Kind of 8	Business/Ind	dustry
2121	within ane. than	Be Completed	Elementery/Secondary (0-12)	College (1-4or	5+)	(Give kind of work done life. DO NOT use retire	ed)		At H	Ome	
d 2	Hygid Hygid Ither Int. II	CO	17. Father's Name (First, Middle, Las	<b>4</b>		- Januarez	18. Mother's Nan	ne (First Middle			
lan	lentai ked o	To Be	Orrie Lee Ta	•			Anna		.,		
Maryland	and M	-	19a. Informent's Name/Relationship		19b	Mailing Address (Stree	et end Number or Ru	rel Route Numi	ber, City or Town	n, Stete, Zip	Code)
	and 2 Palth a 127 is		Marjory S. Bryan	(daughter)	L. I	723 Trenton	Ave S				
Baltimore,	permit. Pagas 1 and 2 should be filed within 72 Department of Health and Mental Hygiane. Important: If item 27 is marked other than "na any injury or other traumetic event, the Med. and 0.00.		20e. Method of Disposition  1 ABurial 2 Cremetion 3 E 4 Donation 5 Other (Special Control of Contro	□Removel from State	20b. Place of cemeter	Disposition (Neme of y, cremetory or other plaidge Memori	ace)	Date	20c. Location	- City or To	wn, State
Ball	Depart Depart Import any inj		21. Signatura of Filheral Service Lice Robert H. Bra	Touch le	سسا	22. Name and Addr Bradsha	ess of Facility  w & Sons  Main St.	Funeral	. Home	D 240	49
j.	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each li		not enter the mode of dy	ing, such as cerdiac	or respiratory	arrest,	210	Approximata Interval Between Onsat and Death
1	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		Color						
		ē	3 7 7042	2	Due to (or as a	consequence of):	above	,			
	outed id ansit	Examiner	Sequentially list conditions	b/m	Due to (or as a	consequence of:	above	<u>د</u>		İ	
o,	rificate be executed ng physician and as the bunal-transit	EX	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury		200 10 (01 00 0	.511354451135 51).					
68760,	hysici the bu	Physician/Medical	thet initiated events resulting in death) Lest	С.	Due to (or as a c	onsequence of):				+-	
9 ×	entific ding p	Mec		d							
Box	attend for us	ian		<b>G</b> ,							
P.O.	that the death cer ed by the attendir detached for use	yslo	Pert II. Other significant conditions	contributing to death b	ut not resulting In	the underlying ceuse g	ivan In Part I	23b. Did			the cause of death?
0	s that	by Ph	CHF;	Demeny	a;	Chronic	Lena	l 10	Yee 20 No	3 □ Prot	pabiy 4 ☐ Unknow
of Vital Records,	The law requires that the death certificate be executed ata has been signed by the attending physician and page 2 should be datached for use as the bunal-transit	Completed b	Insuff.;	0A; S	Dion	Chronic Lef. Ar	emia	24a. Was	s an autopsy ormed?	ava	ere autopsy findings ailable prior to mpletion of causa deeth?
ď	The law ata has page 2	Com				•		10	Yes 2 No	10	Yes 2□No
/ita	ysician: The I is certificata ha director, page	Be	25. Was cese referred to medical examiner?				26. Place of Dea	ith (Check only	one)		
of \	Physician: r this certific and director,	ို	1 Yes 2 No	Hospital: 1 ☐ inpatie		patient on box			idence 8 □Ot		v)
on c	ling P n. Aftar t funera	ion:	27. Manner of Deeth  1 ✓ Natural 5 ☐ Pending	28a. Date of Inju (Month, De	ry 28b. T	njury Wo		28d. Describe	how Injury occu	rred	
Division	daath daath stor: /	lcat	2 Accident investigation 3 Suicide 6 Could not be	On Place of Inc	unu - At hama da		]Yes 2□No	20f Leastin	(Ctroat and No.	har as Du	I Pouto Number
Ö.	or A aftar Direct	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	rm, street, factory, office	'		(Street end Num wn, Stete)	ver of Hufe	l Route Number,
=	To the Hospital or Attending Phywthin Completed and the Purpared Director: After this completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of miner: On the besis of and manner sta	examination and	, deeth occurred at the ti	ime, dete end place opinion, death occu	, and due to the rred at the time,	cause(s) and m date and place	nanner as st , and due to	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	Barel		29c. Licen	se numbar		29d. Date sign	ed (Month,	Dey, Yeer)
				0			00544	99		2 61	And I
			,				00047	000		- 17	00
			30. Name and eddress of person who	completed ceuse of d	eeth (It <i>e</i> m 23a) (		00044	0.00	3/		00
)			30. Name and eddress of person who			Type, Print)			e City,	(	1851

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Chesapeake Beach

10f. Zip Code

20732

13. Was Decedent of Hispanic Origin? (Specify Yas or No-

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death June 3, Day 2000 Year 18:35 STUMPNER AUSTIN 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. Birthplace (State or Foraign Country) 8. Data of Birth (Month, Day, Year) 7. Age (tn yrs. last birthday) 15 M 20 F 86 Yrs. Nov. 10, 1913 MD 10b. County 10c. City, Town or Location 10d. Inside City Limits

1 Yas 25 No

10g. Citizen of What Country?

14. Race - American Indian,

USA

**Physician** /Medical Examiner **Funeral** Director Director natural, or itams 23a or 28a-f : dical Examiner must be notifie Baltimore, Maryland 21215-0020

JOSEPH

5. Social Security Number

10e. Street and Number

10a. Stata

MD

218 34 5914

Usual Residence of Decedent

Calvert

12. Was Decedent Ever in U,S.

3904 Bayview Drive

**Physician** /Medical

Division of Vital Records, P.O. Box 68760.

Examiner within 24 hours after death.

To the Funeral Director: After of completely filled in by the funeral 10

	Nevar Married 2	©©¥as 2 No If Yas, Giva Year or Detes: 1934	-64	1 ☐ Yes 2	No No	Specify:	to mount, atoly	Specify	white	
Eleme	15. Decedent's Edu (Specify only highest grad- intary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(G lift		k done du e retired)	iring most of wo	rking		usinass/Industry	rna
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	ormant's Name/Relationship (Ty llis M. Morgan							ber, City or Town, each, MD		
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29b. Sign	natural and title of certifier			29c.	License	number 1757		29d. Data signe	d (Month, Day, y	
30. Nama	a and address of person who co	empleted cause of death (Item	23a) (Ty	pe, Print)						

State Registrar DR. JOHN PIETROPAOLI

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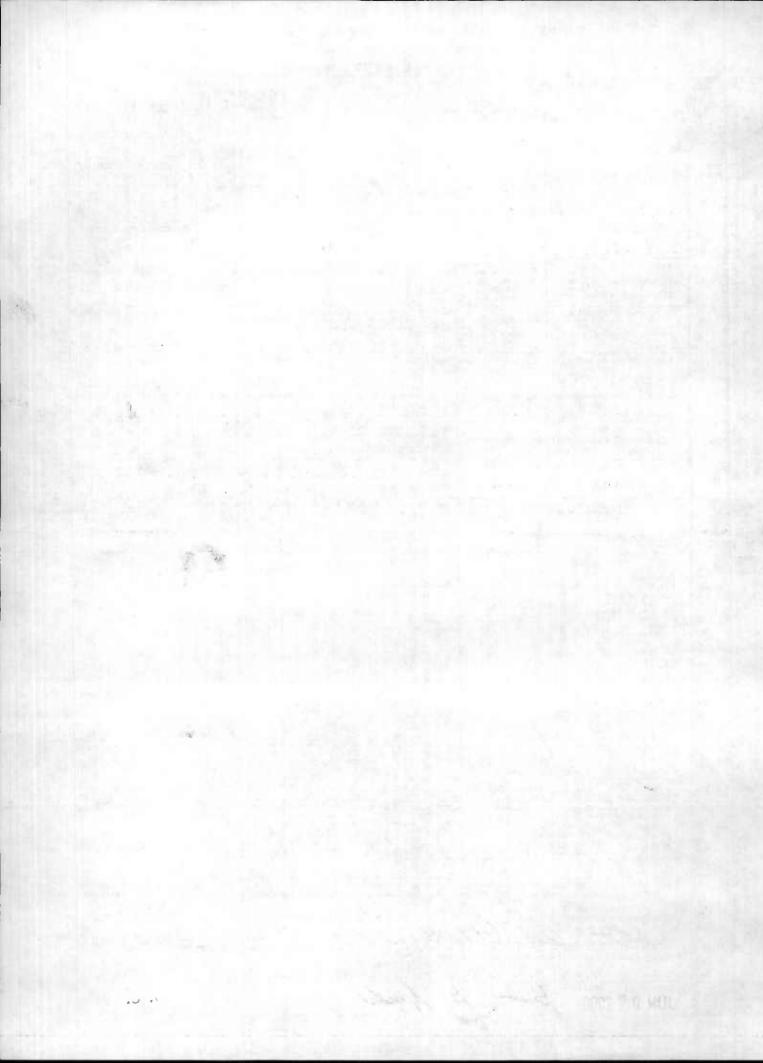
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	/Medical	Vivian Tarpley					April	15, 2000	5:20 PM
	Examiner	4a Facility Nama (If not Institution, giva				4b. City, Town, or L	ocation of Death		
		Doctors Communit		to an in the state of the	If Under 1 Year	Lanham	T 0 Date of D'd		George's
	Funeral Director	5. Social Security Number 6. Sa 199-24-4113	7. Aga (In yrs. 69	Yrs.	Months Days	Hours Min.	8. Data of Birt (Month, Da June 1	7 Year) 930	9. Birthplaca (Stata or Foraign Country) Pennsylvania
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	Man Help	Maryland Prince	Georges's La	nham					1X□ Yas 2□ No
	ther death with the Marylan Herne 23a or 23a-f show inst. must be notified at Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	th will	7206 Lois Lane			20706	ó		United S	States
	ifter death v	11. Marital Status	<ol> <li>Was Decedant Evar in U, Armed Forcas?</li> </ol>	S. 13. W	as Dacedant of H	lispanic Origin? (Sp an, Maxican, Puart	pecify Yas or No Rican, atc.)	14. Race - Bleck.	- Amarican Indian, Whita, etc.
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and	Sans W						• Perry	Malderi Sumania)	
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Baltimore,	ortan Injur	21. Signature of Funeral Sarvice Ligens				ss of Facility Ineral Se			i, naryzana
ä	permit. Pages 1 and 2 Department of Health Important: If Itam 27 i any Injury or other fir office.	Doanna E. Tel	liberry	74	00 Georg	gia Ave.	N.W., Wa	shington	n, D.C. 20012
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,	eath certificate be executed attending physician and for use as the burial-transit clar/Medical Examir	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying	Dua to (o	r as a consaqu	ianca ot):				
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Division	deat ctor: y the	3 Suicide 6 Could not be	28a. Place of Injury - At ho	ma. tarm. stre			28t. Location (	Street and Number	or Rural Routa Number,
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	To the Hospital or Attending Physical Within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral directors and the Attending Medical Certification: To		sician: To the best of my knowner: On the basis of axaminat						
	ithin the office of the omple	29b. Signatura and title of certifier	and mannar stated.		29e Licens	a number		29d. Data signed	(Month, Day, Year)
	F 3 F 0	102 1	a. (11/2	1.6		1852			12,2000
		30. Nama and addrass of person who co	moleted cause of death (trans	23e) (Type 5		. 5 4		ONG	, , , , , ,
	4	Paul A. DeVore, 1	M. D. 4203 Oug	nehurv	Pond H	vattevil	le MD	20781	
	State	31. Data tiled (Month, Day, Year)	32. Registrar's Agna	tura /	1	.,	LU PILL	#V/UI	
	Registrar	JUN 0 7 2000 A	D.	poor					



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Year **Physician** 0630 2000 Chris John Trantules lune /Medical 4e Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year 8. Date of Birth (Month, Day, Year) June 8, 1920 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Yrs. 217 09 9705 79 Director Pennsylvania Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. toside City Limits 28a-f show TY Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Derma 23a or 1037 Pennsylvania Ave. 21742 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygians. Intercentant if fleen 27 is marked other than "netural", or flee any injury or other traumette event 1 □NYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2X Merried Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 2 WW 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 1 2 Coilege (1-4or 5+) Driver Taxi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Trantules John Athena Sharky 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) <u>Belva L. Trantules</u> Wife 1037 Pennsylvania Ave. Hagerstown, Md. 21742 20b. Place of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 □ Buriai 2 □ Cremation 3 □ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Rose Hill Cemetery 6/6/00 Hagerstown, Md. 22. Name and Address of Facility Gerald N. Minnich 21, Schature of Funeral Service License 305 N. Potomac St. Funeral Home Hagerstown Md. 21740 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one ceusa on each line. Approximate Interval Between Onset and Death **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of) Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t, 23b. Dtd tobacco use pontribute to the cause of death? á 1 Yas 2 No 3 Probably 4 Unknown should be det à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1.2 Inpatient Certification: To 1∏ Yes 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of tnjury (Month, Day Year) 27. Menney of Deeth 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? Affer 5 Pending investigation Division 1 Naturei deeth. To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A completely filled in by the f 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide 29e. Certifier edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated. (Check only one)

State Registrar

29b. Signature

attnd add

31. Date filed (Month, Dey, Year)

JUN 0 5 2000

**DHMH 16 Rev 6/95** 

rantulus, Chris John

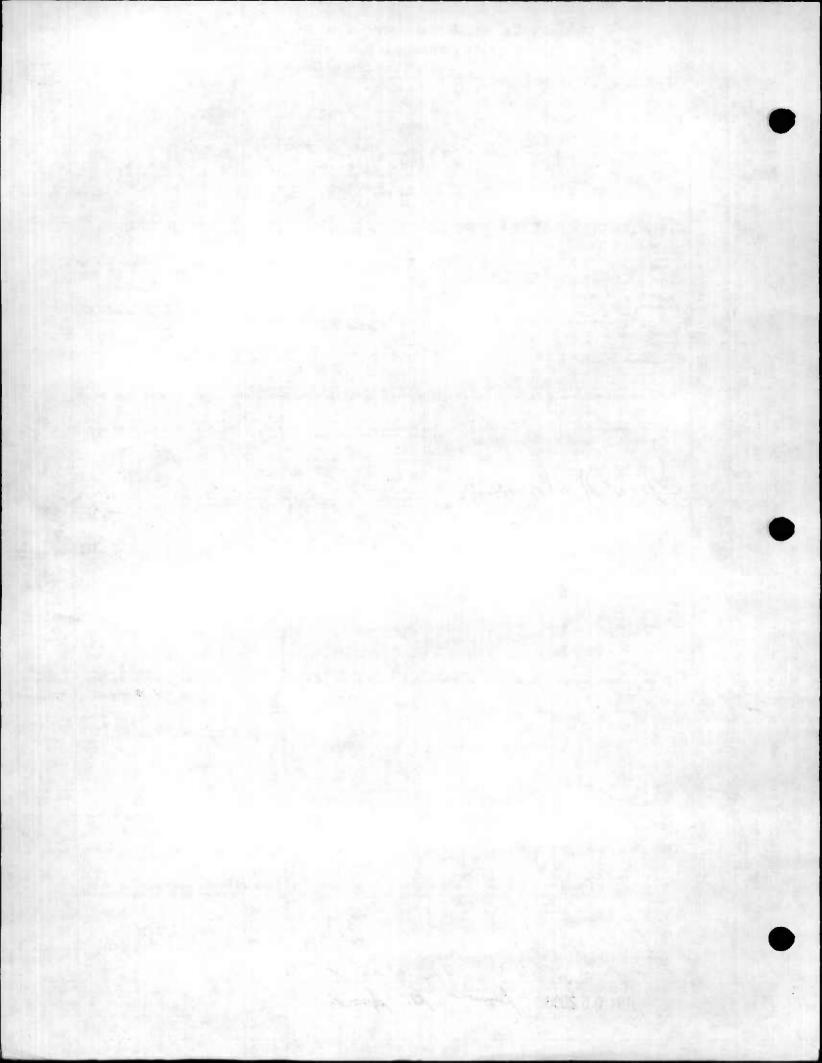
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29c. License number

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State of Maryland / Department of Health and Mental Hygiene

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Director		219–36–7399 Usual Residence of Decedent	1 M 243-F	92	Yrs.					October	7, :	1907	Mar	yland	
with the Maryland a or 28a-f show Lbe notified at	tor	10a. State 10b. County  Maryland Somer	set	10c. City, To	wn or Lo	cation Cris	sfie	eld						10d. Inaide 1≹ Ye	City Limits
ter death with the Maryla items 23a or 28a-f shor iner must be notified at	il Director	10e. Street and Number 103 S. Somerset	Avenue			10f. Zip Co		1817			10g. C	itizen of V		intry?	
hours after death lure?, or items 2 al Examiner mus	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 XXWidowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yas 2 N N If Yes, Give Year or Dates:			Was Decedent I Yes, specify	of His Cuban		gin? (Sp i, Puerto	ecify Yas or No Rican, etc.)	)-	14. Rac Blac			
d within 72 hours ath piene. r than "natural", or i the Medical Exami	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ede completed) College (1-4or 5-	+)	(Give life. L	lent's Usual O kind of work a DO NOT use r	lone du etired)	ring most		ing	Soi		et Co	ounty	
offied work the collect the co		Grade 11 17. Father's Name (First, Middle, Les.	6	I	Educa	ator -		-		e (First, Middle,				ducati	lon
なるはなる	To Be	Alfred J. Lawson	, 					P	Alid	a Ward					
2年 年 三		19a. fnforment's Name/Reletionship								al Route Numb			Stete, Zij	Code)	
Head of the second		Anne B. Muller (20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	20b. Place cemet	of Dispor	sition (Neme of	of r place)	)		Baltimo Date	20c. L	ocetion -	117	own, Steta	
permit. Pages Department of Important: If it any Injury or o		4 □ Donation 5 □ Other (Special Signature of Fundam Service Lice	(y)	Surnyr	-81	Memorial  Name and A				/3/00	Cr	isfie	eld,	MD	
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Medical persecuted ding physician and principles as as the buriel-transit	Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b	Due to (or as a	a conseq	uence of):									
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0 0 %	by Physician	Part II. Other significant conditions of	contributing to deeth bu	t not resulting	In the un	ndarlying caus	e given	In Part i.			Yss :	. /		o the cause bably 4[	
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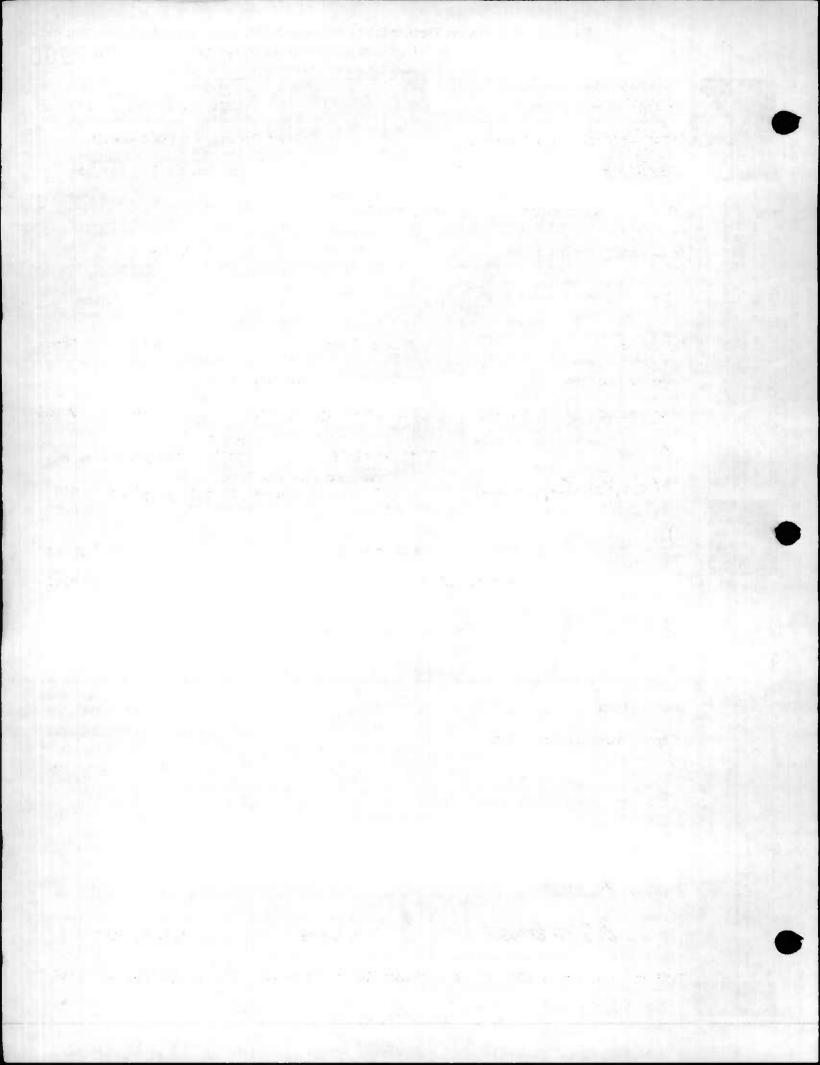
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State of Maryland / Department of Health and Mental Hygiene

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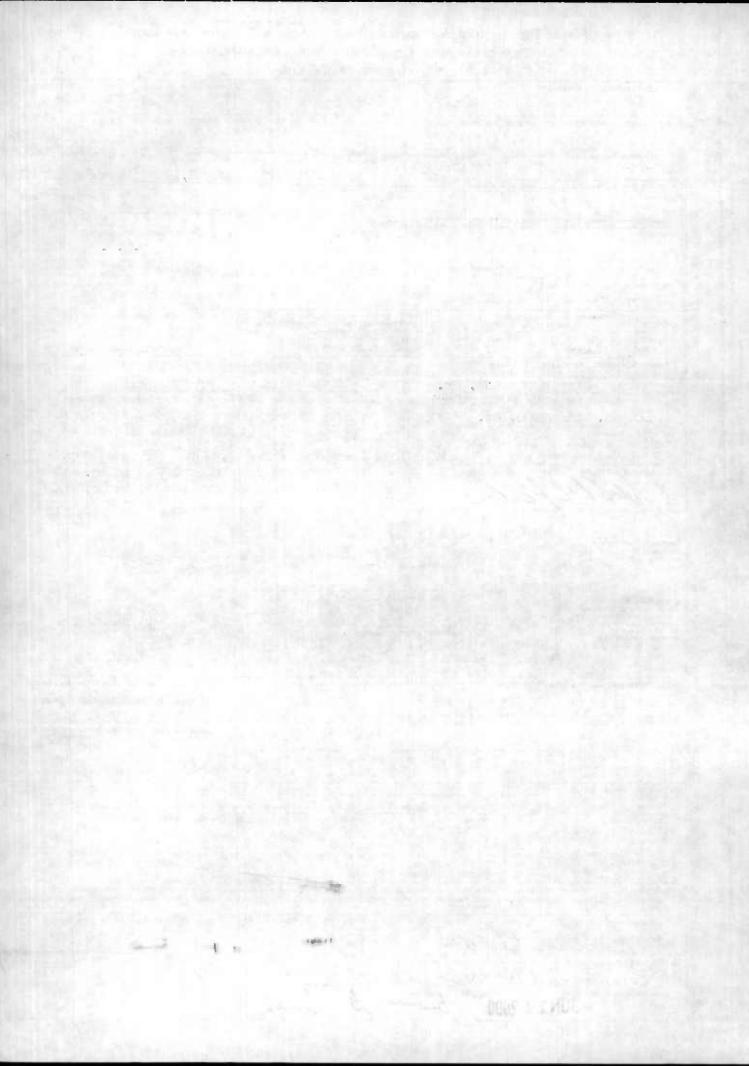
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П	Dharata		1. Decedent's Ne	me (First, Middle, L	ast)							2. Dete of De	eth	Vee	3. Ti	me of Death
	Physic /Medi		Thelma	Estelle W	lines							Month June	4, 2000	Yeer	5:	35 am
Ď.	Exami			(If not institution, gl	ve street and nun	n <i>ber</i> ) .			41	b. City, To	wn, or Lo	cation of Deet	_	y of Deeth		JO 0
71			Manor Ca	are of sil	ver Spr	ing				Silve	er Sr	oring	Mont	gomer	v	
	Funeral	Г	5. Social Security	Number 6.	Sex	7. Age (In yrs.	last birthda			If Under Hours		8. Dete of Bis (Month, De	th Your	9. Birth	plece (S	Stete or Foreign
1	Director		579-09-8 Usuel Residenca		1□ M 2□ F	87	Yrs.	MOTHETS	eys	Hours	IVIII).		, 1913	Mar	yla	nd
	show		10a. Stete	10b. County			ty, Town or							1	IOd. Ins	ide City Limits
	e Me	Ş	Md.	Montgon	nery	E	Burton	sville							1 🗆	Yes 2 No
	ith th	Director	10e. Street end N	umber				10f. Zip Co	de				10g. Citizen of	Whet Cou	ntry?	
	23a		4415 San	ndy Spring	Road			2086	66				U.S.A.			
	r dea	Funeral	11. Marital Status		12. Was Dece Armed For		J,S. 13	Wes Decedent If Yes, specify	of His	spenic Ori	gin? (Spe	cify Yes or No	- 14. Ra	ce - Americ		en,
20	or it	F.		rried 2 Merried	1 ☐ Yes If Yes, Giv	2 X X 10		1□ Yes 2□		Specify:	,	, , ,	Specia		oto.	
21215-0020	n 72 hours effer death with the Meryland "natural", or items 23a or 28a-f show edical Examinat must be notified at	d by	3XIWidowed	4 Divorced	Yeer or Da	ates:		X	X	-,,-			Ороси	Wh	ite	
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9	e filed withing the Hygiene.  other than went, the M			e (First, Middle, Last	<u> </u>		56	OCK CIE	LK	19 Moths	or's Namo	(First Middle	, Meiden Sumer	_	ug	Store
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7	d 2 should by th and Menta 7 is marked traumatic ev	ဥ	John T.	Name/Relationship	(Tunn Print)		10h Ma	ilima Antonno (Ci				Course		Ot-1- 70	0.41	
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2	0 = 0		NewBuriai 2	2 ☐ Cremetion 3 ☐		State	cemetery, cr	emetory or other	r place	9)	1	June 7	200. Location	ony or re	, Ott	,,,,
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ı			23a. Pert1. Enter shock, or he	the diseese, or conference the disease of the disea	plicetions thet co one ceuse on e	sused the dea ech line.	th. Do not e	nter the mode of	dylng	, such es	cardiac o	r respiretory e	rrest,		Interve	ximete el Between
Ÿ.	Physician													i	Onset	end Deeth
	/Medicai Examiner		Immediate Cause disease or condit resulting in death	ion	e. Cond	aestive	Hear	t Failu	ce						2 v	ears
		<u>.</u>	resulting in death	,				equenca of):								
	led Isit	Examiner			ь. Нуре	ertensi	.on								6 y	ears
	and al-trai	xar	Sequentielly list of it eny, leeding to	conditions, immediate		Due to (	or es e conse	equenca of):								
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o.	res that the derigned by the e	Physician	Part II. Other sign	ificant conditions	contributing to de	ath but not res	sulting In the	underlying ceus	e give	n in Pert i.			tobacco usa co			
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ot	Phys this rai di	-	1 ☐ Yes 27 27. Menner of Dea	Mo	1  Ir	npatient 2	ER/Outpetion 28b. Time			4 M Mu			dence 6 Ott		y)	
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isi		Ical	2 ☐ Accident 3 ☐ Suicide	investigation 6	e one Diese	of Internet 84 h				65 2 🗆 1		Of Location /	Street and Alum	hor or Our	al Clause	Alumbar
Division	or Attendent effer deat Director:	Certification:	4 Homlcide	determined	buildin	ig, etc. (Special	ome, term, s fy)	street, factory, of	TICE		-	City or To	Street end Num wn, Stete)	oer or Hure	HOUTE	rvum <i>oer</i> ,
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	N N	29b. Signeture en	d titlerat certifier	ond monn	er stated.		29c. Li	cense	number	-		29d. Date signe	ed (Month.	Dev. Yo	eer)
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			30. Neme end edd	dress of person who												
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Tracy	E.	Wr	ightson
JVW	AME	END	ITEMS:

State of Maryland / Department of Health and Mental Hygiene

MEND IT	EMS: #23 PART I,	27, 28A-F PI	ER MEO	Certificate	of L	Death	Re	g. No.		10001
Physician /Medical	1. Decedent's Name (First, Middle	e, Last)	rl	Wrig			2. Data of Deeth Monthe		990	3. Time of Death 8:35 P.M.
Examiner	4a Facility Name (If not institution 9600 Frankli	n, giva street and number) n Avenue			4t	Seabro	Location of Death	4c. County of		orge's
Funeral Director	5. Social Security Number 213–84–9959		(In yrs. last birt	hday) If Undar 1 Months	Year Deys	If Undar 24 Hrs Hours Min.	8. Dete of Birth (Month, Dey, July 28			iece (Stete or Forei try) nington D
	Usuel Residence of Decedent						2 /			
r mant be negligated and neral Director	Maryland Prince	e George's	10c. City, Towr	brook	`orle		10	g. Citizen of Wh		0d. Inside City Lim 1 ☐ Yas 2 ☐﴿
23a or	9600 Frankl	in Avenue			0706	5		U.S		
d other than 'natural', or itema 23a or 28a-f el event, the Medical Examinar mant be incitified avent, the Medical Examinar mant be incitified Be Completed by Funeral Director	11. Maritel Slalus  1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? ied 1 Yes 2 N If Yes, Give Yeer or Detes:	1000	13. Was Decede If Yes, specif		spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- o Ricen, etc.)	14. Race - Biack, Specify:	White,	
"natural",	15. Decedent (Specify only highes	's Education st grada completed)	16a.	Decedent's Usuet (Give kind of work life. DO NOT use	Occupa done de	tion uring most of wo	king	6b. Kind of Busi	ness/Ind	lustry
d de	Elementery/Secondary (0-12)	Coilega (1-4or 5-			100/100/					
S S	8th	N/A	Mu	sician		40. Mathada Na		Self-em		red
	17. Father's Neme (First, Middle, Philip Glenn	Wrightson,	Sr.				ne (First, Middla, M res Ann B			435
r is marke traumatic To	19e. Informent's Neme/Reletions						ire! Route Number,			
n 27	Philip G. Wrig	htson, Jr.		-		Avenue	Upper Mar			
important: If Nem 27 is any injury or other trac once.	20a. Method of Disposition  1 Librarial 2 Cremetion  4 Donation 5 Other (Sp	3 □Removel from Stete	cemeter	Disposition (Nemo y, cremetory or oth Hill Cem	er place		Dete 2 13,2000	Oc. Location - Ci		<sub>wn, Stete</sub> Maryland
important: It any injury o once.	21. Signature of Euneral Service	Scensee /		22. Name end	Address	s of Fecility L	ee Funera a Ferry R	1 Hame,	Inc	
ding physician and se as the burial-transit and	23a. Pent 1. Enter the disease, or shock, or heer telture. List temmediate Cause (Final disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ACUT  a  b  c	TE NARCO	OTIC, PHE INTOXICA consequence of):	NCY	CLIDINE	AND COCAL			Interval Batween Onset end Deeth
Physician	Pert II. Other significant condition	d		onsequence of): the underlying ca	use give	n in Pert I.				the cause of dea
should should							24e. Wes en		av	ere sutopsy finding allable prior to mpletion of ceuse death?
page 2							DE XO	s 2 No	1,5	Kes 2□No
rector, pa	25. Wes case referred to medical			New York		26. Place of De	eth (Check only one	)		
To E	examiner? 1 ☑ Yes 2 ☐ No	Hospitel:	nt 2 ER/Ou	tpatient 3 DO	Othe	r: 4 Nursing h	lome 5 Resider	nce 6 Dother	(Specify	Scene
tor: After the funeral fraction:	27. Menner of Death  1 Netural 5 Pendin invastig 2 Accident invastig 3 Suicide 6 Could r	et ? es 24TNo	28f Location (Str.	KNOWN	or Rure	il Route Number,				
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pletely file	(Check only 2 Medical 1	Examiner: On the besis of a and menner stet		Vor investigation, i	n my op	inion, deeth occi	irred et the time, da	te and place, an	d dua to	the cause(s)
To the comp	29h. Signature and the of certifier	if Chut	w			number C. M. E.	29	JUNE	(Month,	2000
	30. Nema and addrass of person of Dennis	T. Chuten	10	111	Per	n Stree	t, Baltim	ore, Ma	ryla	and 21201
State Registrar	31. Dete filed (Month, Day, Year)	N1 4 2000	r's Signature	~ &	A	oorks				



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** June 14, 2000 Phillip Charles Allen 11:10 PM /Medical 4s Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Woodlawn 19 Summerfield Road Baltimore If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year)
Jan. 17, 1 6. Sex 7. Age (In vrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 110 M 2□ F Months Days Hours Yes Director 215-01-9004 1916 Maryland Usuel Residence of Decedent 10a Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2♥ No Director Baltimore Woodlawn 10e. Street end Number 10f. Zin Code 10g. Citizen of What Country? 8 21207 U.S. A. 234 19 Summerfield Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Yeer or Detes: 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nant of Health and Mertal Hygiena.
The file of the standard order then natural, or ite with them the seen, the Meadord Examinary or other than the seen, the Meadord Examina Specify: White 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 3 Salesman Chemical Manufacturer 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Thomas Victor Allen Doris Madeline McNulty 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Doris M. Allen 19 Summerfield Road, Woodlawn, Maryland 21207 (Wife) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Department of Important: If Is any Injury or o 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from Stete Baltimore Wash. Crematory 6/19/00 Laurel, Maryland 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of FacilityLoring Byers Funeral Directors, Inc une Charvice Licensee 8728 Liberty Road, Randallstown, Maryland 21133 he distance or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, in tellure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical - infacet dementia Examiner Due to (or es a consequence of): Physician/Medical Examiner burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Box 68760. attending physician for usa as tha buris thet initieted events resulting In death) Lest Due to (or es e consequence of) P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Carolorascular Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Be Completed 24a. Wes en autopsy performed? paga 2 1 Yes 2 No 1 TYes 2 No cartificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury st Work? 28d. Describe how injury occurred After 1- Neturel Injun 5 Pending death. Investigation 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined To the Hospital or Atterwithin 24 hours after dea To the Funeral Director complately filled in by the 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide

State

29e. Certifier

29b, Signature and fitte of certifier

Registrar **DHMH 16 Rev 6/95** 

WEST

end menner steted.

32. Regisyar's Signeture

end eddress of person who completed cause of deeth (Item 23a) (1999)

ROSEN BERG

2000

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

TOWSON

_	1. Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No. 00	19083	
Physician	MARIA M. ARIAS	Adamsh	5, Day 2000 Yaar		
/Medical Examiner	4a Fscility Name (If not institution, give street and number)  4b. City, Town, or Lo	ocation of Deet			
	SOUTHERN MARYLAND HOSPITAL CLINTON		P.G.		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 1 Usual Rasidence of Decedent	8. Dete of Bir (Month, De AUG.		irthplece (State or For Sountry) SALVADO	
or 28a-f show be notified at Director	10a. State DC 10b. County 10c. City, Town or Location WASHINGTON	Labor.		10d. Inside City Lin	
	10e. Street and Number 1329 RANDOLPH STREET N.W. 20011		10g. Citizen of What C		
Examiner must	11. Marritet Status  1 □ Nevar Married  1 □ Nevar Married  2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Wes Decedent Ever in U, S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Yeer or Dates:  13. Was Decedent of Hispanic Origin? (Spill Yes, apecify Cuben, Mexican, Puerto 1 □ Yes 2 □ No Specify:	acify Yes or No Rican, etc.)		nerican Indian, ita, etc. SPANIC	
ygiene. wer than "natum it, the Medical Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usuat Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Busines	s/industry	
than the Ma	Elementary/Secondary (0-12) College (1-4or 5+)		SELF EMP	LOYED	
	JIH	e (First, Middle	, Maiden Sumame)	20122	
Mental F srked out affic even To Be	FELIX ARIAS LUC		AMBANO		
and in	19a. Informent's Name/Retationship (Type, Print)  19b. Mailing Address (Street end Number or Rura				
m 27	TERESA ARIAS (DAUGHTER) 1329 RANDOLPH STRE				
ant: If the lary or of	20a. Mathod of Disposition  1 Buriat 2 Cremation 3 Removat from State 4 Donation 5 Other (Specify)  20b. Plece of Disposition (Nama of cametary, crematory or other place)  LINCOLN CEMETERY  6	Date / 9 / 0 0	20c. Location - City of SUITLAND	or Town, State ), MARYLAN	
Depart Import any in	21. Signature of Fugeral Service Licensee  22. Name and Address of Facility  AUSTIN ROYSTER F  3821 14TH ST. N.	TUNERA W. WA	L HOME SH,D.C. 2	20011	
y the attending physician and ached for use as the burial-transit and property sician/Medical Examiner	Immediate Ceusa (Finel disease or condition resulting in deeth)  a. Substituted Aferroform  Due to (or as a consequence of):  Cause (Disease or thirty the initiated events resulting in death) Last  d. Endshage Reval Di	L.	2	Unknow Unknow	
for for	Part II. Other significant conditions contributing to death but not resulting to the underlying cause given in Part I.		tobacco uss contribu	ts to the cause of de	
een signed by hould be detacl		10	Yss 2 No 3	Probably 4 Unk	
has b			ormed?	. Were autopsy findin available prior to completion of cause of death?	
s certificate h director, page To Be Corr	25. Was case referred to medical 26. Placa of Death				
0.0		me 5□Resi	dence 8 Other (Sp	ecity)	
iffer death.  Nifector: After in by the funer  rtification.	1 ☐ Natural 5 ☐ Pending (Month, Dey Year) Injury Work? 2 ☐ Accident invastigation M 1 ☐ Yes 2 ☐ No		how injury occurred  Street end Number or I wn, Stete)	Rurel Route Number,	
within 24 hours of To the Funeral Completely filled	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, if the basis of examination and/or invastigation, in my opinion, death occurred at the time.	and dua to tha red et tha tima,	cause(s) and menner data end ptece, end d	as stated. ue to the ceuse(s)	
To the compl	29b. Signeture end title of certifier 29c, License number		29d. Date signed (Mo	nth, Day, Year)	
	Hallyodler no DE0454		Jure,	6,2000	
	30. Name and address of person will completed cause of daeth (Itam-23a) (Typq, Print)	WINC	SER RO	Fran	
State Registrar	31. Deta filed (Month, Day, Year)			110)	

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey Year Month Physician HILLEL ALELISHUILI 14 2000 10:05AM JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN, BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 213-82-5508 100 M 20 F Yrs Director FEB.4,1924 GEORGIA - USSR Usual Residence of Decedent 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits **ehow** Items 23s or 28s-f shortiner must be notified at 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3504 OLYMPIA AVENUE 21215 U.S.A. Funeral 14. Race - American Indien, Bleck, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: If item 27 ie marked other than "netural!" on their treumatic every injury or other treumatic every ence. 1 Never Married 2 N Married 1 Yes 2X No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 OWNER CLOTHING 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be MORDECHAI ALELISHVILI CHANA DAVARASHVILI 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) NATALA ALELISHVILI / WIFE 3504 OLYMPIA AVENUE - BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX Burial 2 Cremetion 3 Removel from State SHEARITH ISRAEL CONG. 6/15/00 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical · CORONARY Examiner Due to (or as a consequence of) Physician/Medical Examiner NEOMIONIA physician and s the burlet-transit The law requires that the deeth certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown SEIZURES Records, þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? CEREBROVASCULAR ACCIDENT 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital al or Attending Physicien: To sefter deeth.
I Director: After this certificated in by the funeral director, pe Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or A within 24 hours efter To the Funerel Direcompiately filled in b † McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 19.8.RAO.M.O 043462 JUNE 14, 2000 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1<. 5. RA o - M.D HOSPITAL CENTER, RANDALLSTOWN, MO NORTHWEST 31. Date liled (Month, Day, Year) 32. Registrar's Signature

**DHMH 16 Rev 6/95** 

State

Registrar

JUN 1 6 2000

Oreka

	Certificate of Death	Reg. No.	0 19085							
Physician	1. Decedent's Name (First, Middle, Last) OTIS ALEXANDER	2. Date of Death Month Dey JUNE 11, 2000	Year 3. Tima of Death							
/Medical Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town,	or Location of Death 4c. County	0.40 1.11							
Funeral Director	264-09-8855 XX 20 83 Yrs.		9. Birthplace (State or Foreign Country)  Ch							
Manyland 4 show and at	Usual Residence of Decedent  10a. State  10b. County  MD • PRINCE GEORGE CHEVERLY		10d. Inside City Limits 1 ☐ Yes 2 ☐ No							
I Z I Z 13-0020 led within 72 hours efter deeth with the Mai led within 72 hours efter deeth with the Mai led within natural, or hema 23s or 28s-f s nor than natural, or hema 23s or 28s-f s it, pre Medical Examiner must be notified Completed by Funeral Director	10e. Street and Number 10f. Zip Code 20785	10g. Citizen of V USA	10g. Citizen of What Country? USA							
21215-0020  d within 72 hours elter daeth with the Maryland piece, r than "natural", or flema 23a or 28a-f show the Madical Examiner must be notified at completed by Funeral Director	11. Marital Status  12. Wes Decedent Ever in U,S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt.  14. Wes Decedent Ever in U,S. Armed Forces? 15. Was Decedent of Hispanic Origin? 16. Yes, specify Cuban, Mexican, Pt.  17. Yes 2 □ No 18.	? (Specify Yes or No- uerto Rican, etc.)  14. Rac Blac  Specify	ce - American Indian, ck, White, etc.							
	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of	working 16b. Kind of Br	usiness/Industry							
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Maryland de the de 2 should be filed to and Mental language traumatic evant, To Be C.	17. Father's Name (First, Middle, Last)  18. Mother's I	Name (First, Middle, Maiden Suman NE HARRINGTON	(First, Middle, Maiden Sumame)							
Peges 1 en nent of Heel Mrt: If Nem 2	19e. Informant's Name/Relationship (Type, Print)  LINNETTE C. ALEXANDER DAUGHTER 6210 CHEVERLY PARK									
	20a. Method of Disposition  1  Burial 2  Genetion 3  Removal from State 4  Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetary, cremetory or other place)  METRO CREMATORY	Date 20c. Location - 6/23 BALTO.	City or Town, State							
Baltime permit. Peg Department Importent: In any Injury o	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  2501 GWYNNS FALLS	NUTTER FUNERAL HOPKWY BALTIMORE,								
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Anthuo Suterio Carbo VA  Due to (or as a consequence of):	avar Diseas	e Yeans							
ox 68760, sertificate be executed ding physician and se es the bunk-transit	Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):									
deeth cer deeth cer e attendin od for use	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did tohacco usa co	23b. Did tobacco use contribute to the cause of death							
Ords, P.O. Box requires that the deeth cereen signed by the attendin hould be detached for use	End Stage Renal Disease		1 Yee 2 No 3 Probably 4 d Unknown							
Peen Peen Peen Peen Peen Peen Peen Peen	Dementia	24e. Wes an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?							
I Rec The law ata has b page 2 s	Peninhanal Vasculan Diverse	1 ☐ Yes 2 🗓 No	1 Yas 2 No							
/ita	25. Wes cese referred to medicet examiner?	Deeth (Check only one)								
After this co funeral dire	To inpatient 22 EN Outpatient 30 DOA 40 Nursin	28a. Dete of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28b. Time of Sec. Injury at Work?  28c. Injury at Work?								
Division of the or Attending P tra after death.  al Director: After the in by the funers Certification:	2 Accident 3 Suicide 4 Homicide  28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Numb City or Town, State)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Division or To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) end menner as steted.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.									
To the Within To the compl	290. Signature and title of certifier 29c. License number		ed (Month, Day, Year)							
A =	Chuldwellere In 20185	2 JUNE 1	2000							
9	30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  PAUL A. DEVORE MD 4203 YUEENSBURY	Rd HYSTISU	CLE MD 2018/							
State Registrar	31. Date filed (Month, Day, Year)  JUN 1 6 2000  32. Registrar's Signeture									

Registrar

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State of Maryland / Department of Health and Mental Hygiene 19086 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** ELIZABETH 8: ANDRA 16 AM JUNE 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ENTER BALTIMORE JREATER BALTIMORE MEDICAL TOWSON If Undar 24 Hrs. Hours Min. If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, 5. Social Security Number **Funeral** Months Days 212-60-4866 1□M 20 F 8 Yrs Director Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yas 2 No BALTIMORE Directo MARYLAND Nerra 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? FRANKLIN STREET 22 USA, Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Black, Whita, atc. Was Decedant Evar in U.S. Armed Forcas? 11. Maritai Status 1 Yas 2 No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married natural, or Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BALTO, CITY PUBLIC SCHOOLS EDUCATOR VRS. 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Pages 1 and 2 should be nent of Health and Mental is marked SUSIE GEORGE ADAMS RUSS 2 19s. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 51. KOBERT B. BLACK Department of Health Important: If Item 27 BALTIMORE, MO. 21223

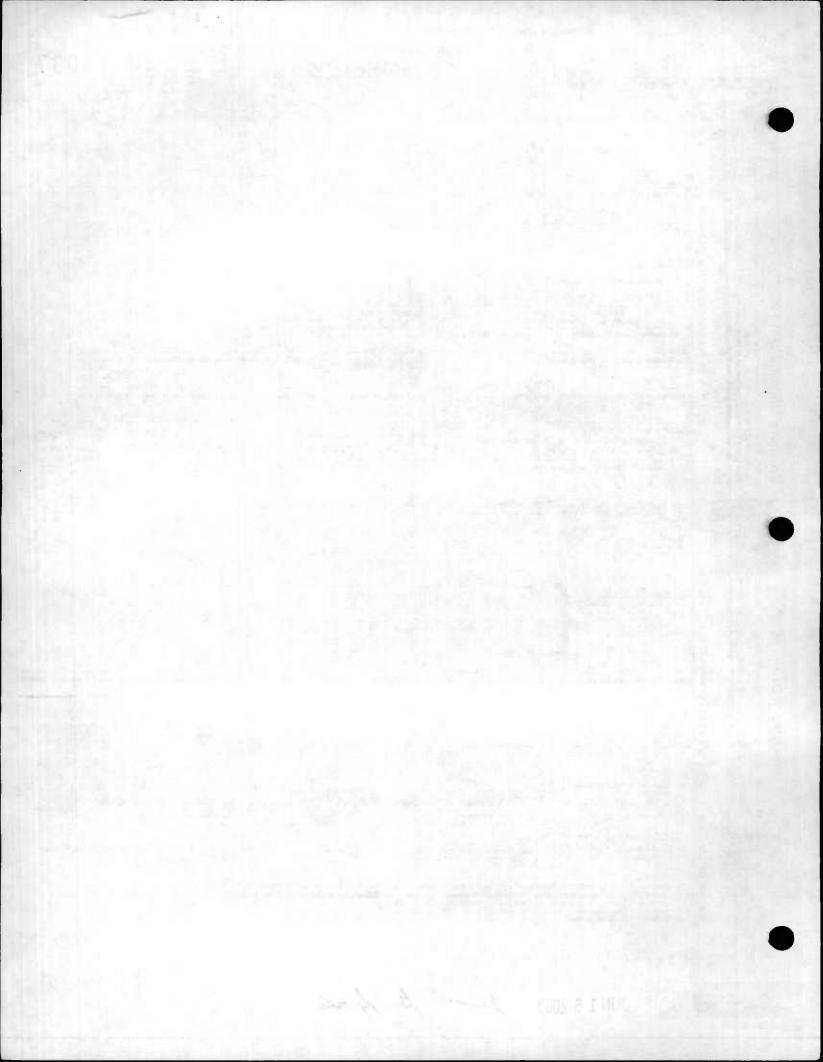
20c. Location - City or Town, Stata 1122 W. FRANKLIN (HUSBAND) 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20a. Mathod of Disposition 1 Buriai 2 ☐ Cramation 3 ☐ Removal from Stata EMETERY 6-16-00 ARBUTUS, MARYLAND 4 ☐ Donation ← ☐ Othar (Specify) Sarvice Licens 22. Nama and Addrass of Facility 21. Signatuse une TR. FUNERAL HOME BROWN JOSEPH AVE. BALTO, MD. 2121 2140 FULTON N. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Cause (Finai Cancer NSCLCa 2 Monts disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Examiner physician and the burial-transit Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated avants rasulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yss 2 ☐ No 3♥ Probably 4□ Unknown à 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy parformed? Completed hes 1 Yas 2 No 1 Yas 2 No 25. Was casa ratarred to medical axaminar? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Othar (Specify) edical Certification: To 1 Yas 20 No N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral o 27. Mannar of Death 28a. Data of injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending invastigation s after death.

I Director: After de in by the fun 1 Yas 2 No 2 Accident 8 Could not be datermined 28f. Location (Streat end Number or Rural Routa Number, City or Town, Steta) 3 ☐ Suicida 28a. Piaca of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. Licansa number 29d. Data signed (Month, Dey, Year) 29b. Signatura and titla of certifiar 2000 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, P(int) JORK 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JUN 1 6 2000 Registrar

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State of Manuand / Department of Health and Mental Hydiene

	4.6			25/00 AH			Certificate of	Death		neg. No.	0	19087
ician dical niner	1. Decedent's Name (First, Middle, Last)  TOAN STAMMUZ  4s Facility Name (If not institution, give street and number)  4b. City, Town, or Loc						2. Date of De Month  July & Death	Day Year 4: 40				
Funeral Director		Northwest Hospital Center  5. Social Security Number  106-36-3927  Conter  6. Sex  1 M 2CXF  6.7  Usual Residence of Decedent		fin yrs. last birth 7	Randalls  vrs. last birthday)   If Under 1 Year   If Under 24 Hrs.  Months   Days   Hours   Min.			th ly, Year)				
or than "natural", or tisms 23s or 28s-f show it, the Medical Exeminer must be notified at Completed by Funeral Director	_	. State	10b. County		1	Oc. City, Town	or Location				1	10d. Inside City Lim
		MD	Balti	more		Pikesv				1 ☐ Yes 2 🔀 I		
	106	8310 Scotts Level Road					10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.			
		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in the Armed Forces?  1 Yes, Give Year or Dates:			er in U,S.	13. Wes Decedent of H If Yes, specify Cubi 1 ☐ Yes 2 No	ecify Yes or No Rican, etc.)	Bla	14. Race - American Indian, Black, Whita, atc. SpecifyBlack			
		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired)				Business/Ir	ndustry	
Be Co	17.	Father's Name	(First, Middle, L	ast)		I Ho	memaker	18. Mother's Nam	Own Home ne (First, Middle, Maiden Surname)			
ToB	C	Larence	V. Hin	kson				Dorothy F	rederio	ca Cado	gan H	inkson
	19	a. Informant's No							al Route Number, City or Town, Stata, Zip Code)			
	-			Husband)			O Scotts Le					
ury or other t	208	20a. Method of Disposition  1  Surial 2  Cremetion 3  Removel from State  4								ille,	Maryland	
Í	21.	Signature of Fy	pofol Sorrico L	icensee			22. Name and Addre 8728 Libert		-			
e as the burial-transit	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
clan		Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.						23b. Did tobacco use contribute to the cause of dea				
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y Physician/M	Par	III. Other signii	icant condition	ss contributing to		Lati	he underlying ceuse giv	en in Parti.	23b. Did		3 Pro	11
by	-	Til. Otner signii	icant condition	as contributing to			he underlying ceuse giv	en in Paπ I.	1 🗆 24a. Was		3 Pro	11
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year Edith M. Bruchev Sune 14 1330 /Medical 7000 4e. Fecllity Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Augsburg Lutheran Home, 6825 Campfield Road Lochearn Baltimore 8. Date of Birth (Month, Day, Year)
Dec. 18, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months 1□ M 2 F 213-36-0134 Director Dec. 1904 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-4 show any Injury or other traumetic avent, the Medical Examinar Instal be no iffed at 10d. Inside City Limits MD Director 1 ☐ Yes 2 No Baltimore Lochearn 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6811 Campfield Road U.S.A.
14. Race - American Indian, White, etc. Funeral 21207 12. Was Decadent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 No Specify: þ Specify: 3 2 Widowed 4 □ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Musician Private Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry L. Suman Sophia Lemmert 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Brown (Daughter) 8279 Vosges Road, Baltimore, Maryland 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Locetion - City or Town, State Date 6/19/00 Violetville, Maryland 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul Lutheran Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Icheiners 22004 Examiner Due to (or es e consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest bunal-tran and Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical the Due to (or es e consequença of): attending p signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 275No 3 Probably 4 Unknown tracheobrenchitis ģ been si Completed 24b. Were autopsy findings available prior to 24a. Was an eutopsy completion of cause of deeth? page 2 1 ☐ Yes 25No 1 ☐ Yes 2 ☐ No funeral director, 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Netural efter death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours e To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and menner stated. 29a. Certifier Medical

State Registrar

completely

(Check only one)

29b. Signature and title of certifier

30. Name end eddress of person w

Madis

MD 7220 32. Registrar's Signature

o completed cause of death (Item 23e) (Type, Print)

Park Heights

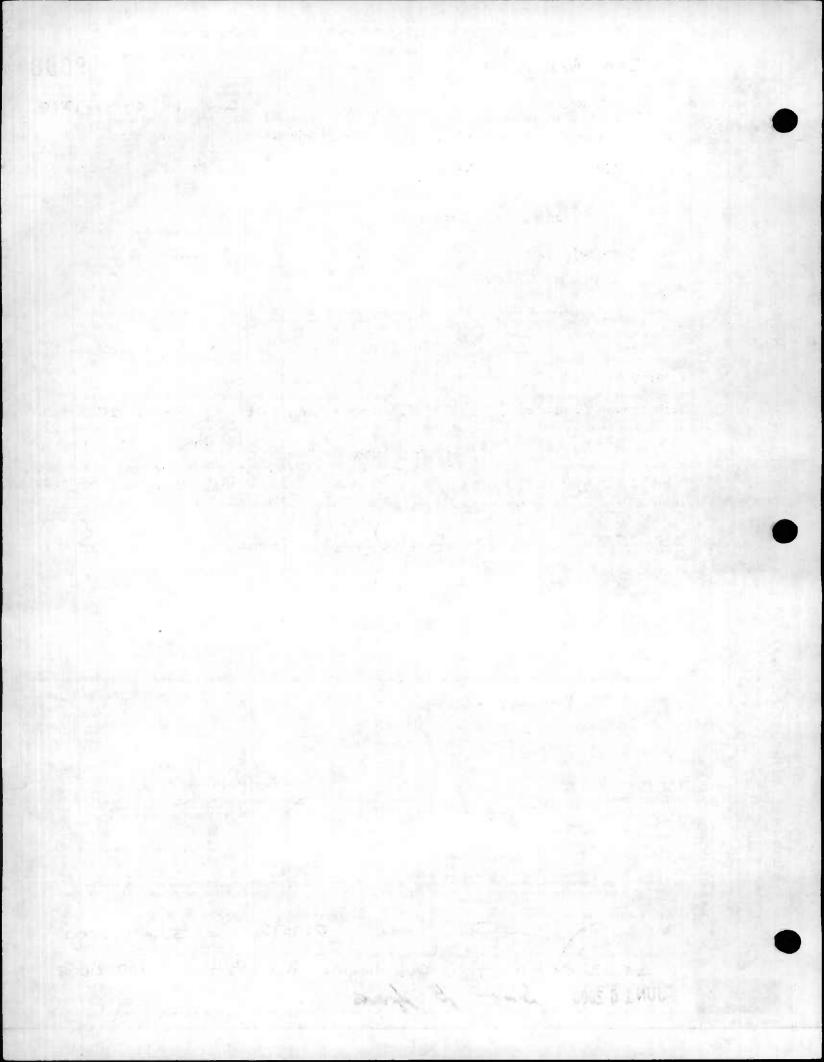
29c. License number

037573

29d. Date signed (Month, Day, Year)

Battimore

June 14,2000



	Decedent's Neme (First, Middle, Last)	State of Marylai		icate of		Re 2. Date of Deat	eg. No.		Time of Death	
Physician /Medical	JOSEPH	4b. City. Town, or Loc	Month: SUNG			5:30 Am				
Examiner	4a Facility Name (If not institution, give so MARBOR WOSPI									
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs. lest birthdey) If Under I Year   If U					Year)	Birthplaca (Stete or Foreign Country)		
Sa or 28a-f show at he notified at il Director	Usual Residence of Decedenf  10a. State 10b. County							1		
			ity, Town or Location						Inside City Limits	
	Md. Anne Arundel Co. Baltimore 106. Street and Number 109. Citizen of What Country?								- 26	
if, or hams 23s startiner must by Furneral		2. Was Decedent Ever in U Armed Forces? 1 1 Yes 2 No If Yes, Give Year or Dates: WWI	10	21225 Decedent of H s, specify Cubi	lispanic Orlgin? (Spe an, Mexican, Puerto F	city Yes or No- lican, etc.)	Black	- American Ir k, White, etc. white	ndian,	
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er traum	John R. Crumlish	III (Executo	r) 1615	Cheste	and Number or Rura r Road, Cl			Stete, Zip Cod 11619	(e)	
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detached for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobecco use confribute to the cause of de			
by Phy	GASTRIC		UZV	1 √Yss 2 No 3 Probably 4 Unkno						
Completed by Physician/M					G i	24a. Was a perform	n autopsy med?	availab	autopsy findings ble prior to etion of cause th?	
Com						1 🗆 Y	es al No	1 □ Y€	s all No	
ctor.	25. Was case referred to medical examiner?	and the land		04	26. Place of Death	(Check only on	10)			
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Atter fune fune fune	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Dey Year) Injury Work?  M 1 ☐ Yes 2 ☐ No					on (Street and Number or Rural Route Number,			
ed in by	4 Homicide determined	28e. Placa of Injury - At I building, etc. (Speci	nome, farm, street, ify)	factory, office		28t, Location (Si City or Town		er or Hurel Ho	oute Number,	
To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner es stated.  Check only one)  Contitying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner es stated.									
Me	29b. Signature end title of certifier			29c. Licens	c. License number 29d. Date signed (Month, Day,			, Year)		
	Impamals	mo		RE.	5000		JUNE	15	2000	
)	30. Name and address of person who con TSHERING Ampo	pleted cause of death (Ite , HAKBOR KO	m 23a) (Type, Prin	ENTL	BALTI	MORE!	HANOVE	2123 R STR	9. REET.	
State Registrar	31. Date filed (Month, Dey, Year)  JUN 1 6 2	32. Registrar's Sign	nature	Lon	, 2001				-	

State of Maryland / Department of Health and Mental Hygiene 9090 Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12,ay **Physician** Joseph Bujnowski June 2000 6:50 P.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Country Grove Estates Glen Burnie Anne Arundel Co. If Undar 1 Yaar | Months | Days If Undar 24 Hrs. 8. Date of Birth (Month, Day, April 12, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 10XM 20 F Baftimore, Maryland 219-12-8691 87 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Mary land Anne Arundel Co. Glen Burnie Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 6 Ivy Lane 21060 United States of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian Biack, White, atc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or her any injury or other traumetic event, the Medical Exempton. 1 XYes 2 No W.W. II If Yes, Give Year or Datas: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Nidowed 4 Divorced Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementary/Secondary (0-12) Meat Cutter Albert F. Goetz, Inc. 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fathar's Name (First, Middle, Last) Adam Bujnowski Monica Waszkiewicz 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Yvonne Nash(Niece) 427 Wake Robin Road Cockeysville, Maryland 21030 20b. Placa of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Druid Ridge Cemetery 6/15/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee Jeffrey L. 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. Gair 1050 York Rd. Towson, Md. 21204 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** e montia /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner Meerid attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the attending p Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown (Seas-UN þ page 2 should t 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? Completed completion of causa of deeth? cartificate hes 2 1 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) To Hospital: rours after death.
reral Director: After this cr 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 6 Could not be 3 Suicida 28e. Piace of Injury - At home, farm, streef, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Continuing Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29e. Certifier (Check only one) 29b. Signatura and titla of certifier 29c. Licansa number 29d. Date signad (Month, Dav. Year) 30. Name and address of person who coppleted cause of death (Item 23a) (Type, Print)

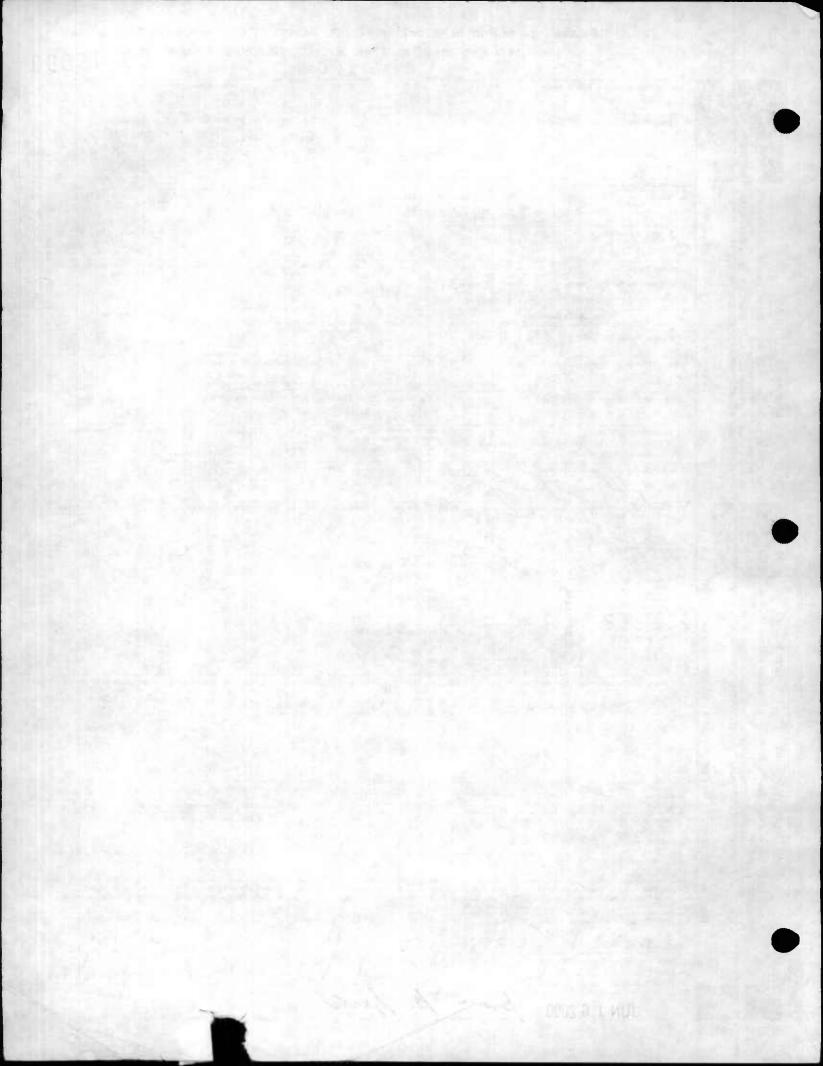
State Registrar

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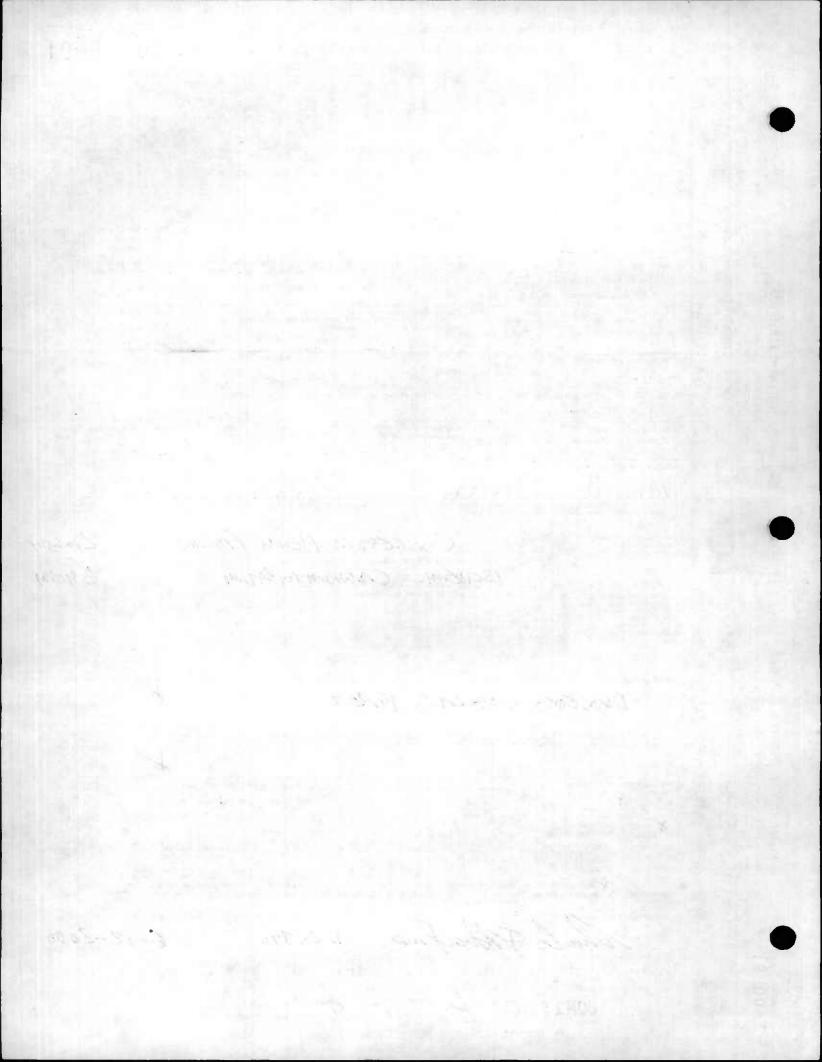
31. Date filed (Month, Day, Year)

32 Registrar's Signature

Kes vill



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프로트등		20a. Method of Dis	sposition			Plece of Disp	osition (Nema of metory or other pl		Date	20c. Location - C	ity or Town, Stete	
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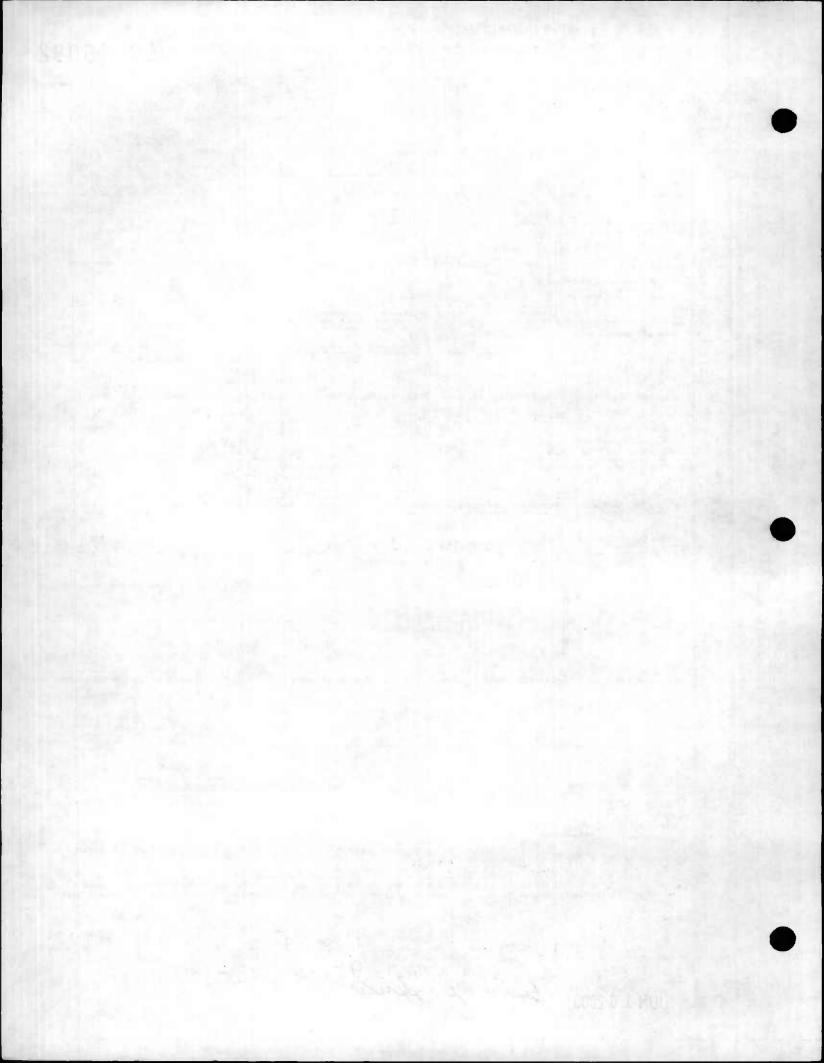


# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 19092 Certificate of Death Reg. No.

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DHMH 16 Rev 6/95

Joseph Bradshaw



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 19093 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 10 43HRS CHRISTINE E. BRADLEY TUNE 12 2000 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSP (TAL AGNES BALTIMORE N/A If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Deys Months Hours 1 M 2 K F 215-09-7049 Apr 5, MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard 1 Yes 2√ No Columbia 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 7080 Cradlerock Way 21045 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) financial advisor department store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara A. Waechter James L. Erobrink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Bradley/son 118 N. Port Street Baltimore, MD 21224 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Stryice Licensee Ronald S. Wades Derector 22. Neme and Address of Facility Mul) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. 6BAYS Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events Due to (or as e consequenca of): that initieted events resulting in death) Last Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown METASTATIC COLON CANCER 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? DEEP VENOUS THROMBOSIS 28 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

attending physician and for use as the bunet-transit 68760 ed by the a page certificate Attending death. after 5 To the Hospital
within 24 hours
To the Funeral C

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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filed within 72 hours after

permit. Peges 1 and 2 should be Depertment of Health end Mental Important: If Item 27 Is marked or sny Injury or other traumatic eve

**Physician** 

/Medical

Examiner

Examiner

Physician/Medical

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Completed

Be

Medical Certification: To

29a. Certifier

29b. Signature and title of certifier

Baltimore, Maryland 21215-0020

Director

Funeral

py

Completed

State Registrar

M.D.

29c. License number

Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

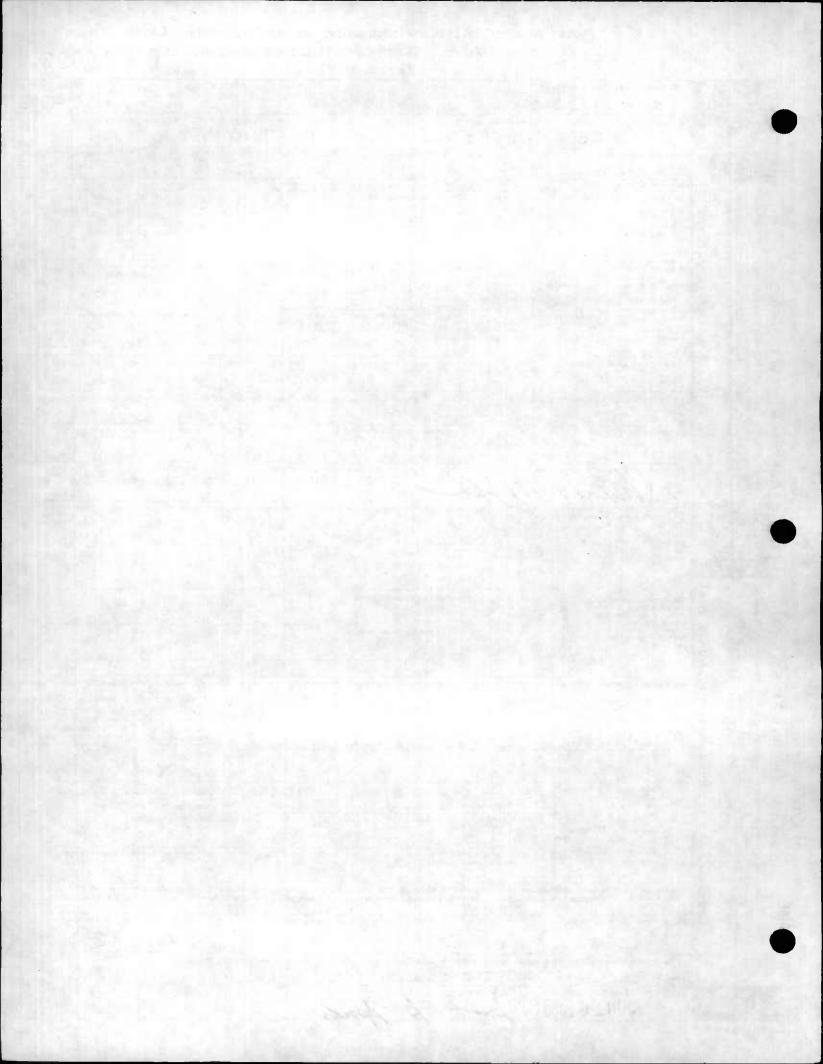
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2000 JUNE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NANA CEASAR; ST AGNES HOSPITAL; 900 CATON AVENUE; BALTIMURE MD 21229

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 1 6 2000



Physicia /Medica	ın	EMS: #23 PART  1. Decedent's Name (First, MARILYN M.	Middle, Las	1)		=1.5				2.	Dete of De Month INC 1(	eth Dey	Year	3. Tima of Death 450 am
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Funeral Director		Atlantic Ge 5. Social Security Number 155-22-8198	6. Se		Age (In yrs. 69	last birthde Yrs	Months			Min.	Date of Bir (Month, Da	th ly, Year)	9. Birt	ter hpleca (State or Foreignatry) NJ
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iffed at	ctor		orces	ter		y, Town or Ocean	City							10d. Inside City Limit:
	al Director	10e. Street and Number One 66th Str	eet #	102				Code 1842	2			10g. Citizen o	f What Co SA	untry?
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To the Hospital or Atlanding Physician: The lew requires that the within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by to completely filled in by the funeral director, page 2 should be detach.

Medical Certification: To Be Completed by Phy

Division of Vital Records, P.(

PULMONARY EMPHYSEMA, HYPERTENSIVE AND ATHEROSCLEROTIC

CARDIOVASCULAR DISEASE

25. Wes case referred to medicel examinar?
1 X Yea 2 □ No 27. Manner of Death

5 Pending investigation 1 Neturel 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

FOUND: Pay Year) 6-10-00

Hospital: 1 ☐ Inpatient 2 🔀 ER/Outpetient 3 ☐ DOA 28b. Time of FOUND: 4:05

28c. Injury at Work? 1 Yes 28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

24e. Wes an autopsy performed?

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signetur

29c. License number O.C.M.E. 29d. Dete signed (Month, Day, Year)

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy lindings available prior to completion of cause of death?

1 EYes 2 □ No

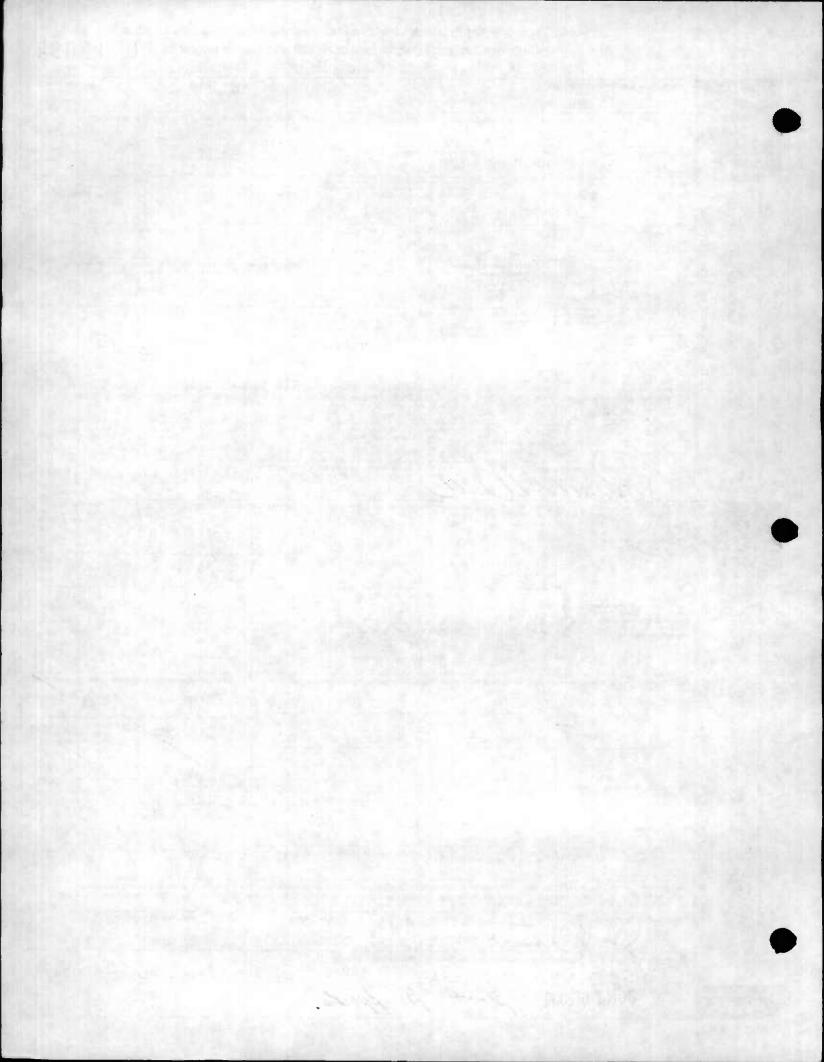
June 11, 2000

d ceuse of death (Item 23a) (Type, Print)

an 31. Date file 2000

111 Penn Street, Baltimore, Maryland 21201

State Registrar



State of Maryland / Department of Health and Mental Hygiene 9095 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth **Physician** FRANK P. BOLEK, SR. June 7, 2000 1:32 PM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 8549 Newark Road Newark Worcester If Under 24 Hrs. Birthplece (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Dey, Year) July 18, 1924 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys Hours 1 X M 2 ☐ F Months 75 Yrs Director 061-18-8728 Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Itam 27 le marked other than "natural", or items 23a or 28a-f eho other traumatic event, the Medical Examinar mail be notified at MD Worcester Newark 1 ☐ Yes 2 € No Director 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8549 Newark Road 21841 USA permit. Peges 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Islam 27 Is marked other than "natural", or Itams 23, any Injury or other traumatic avent, the Medical Example mains. Funeral Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S Armed Forces? 14. Rece - American Indien. 11. Maritel Stetus Bleck, White, etc. 1 XYes 2 No If Yes, Give Yeer or Detes: WWII 1 ☐ Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 builder construction 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Joseph P. Bolek Mary C. Cupochic Lo 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Mrs. Bolek/spouse 8549 Newark Road Newark, MD 21841 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☑ Donetion 5 ☐ Other (Specify) Konald S. Wade 22 Name end Address of Fecility State Anatomy Board 655 W. Baltimore Street Dipector rece Baltimore, MD 21201 26a. Pert1. Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical tmmediete Ceuse (Finel disease or condition resulting in death) Examiner Examiner ovohown law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieled events resulting in death) Lest Due to (or es a consequence of) and burial-tran Records, P.O. Box 68760, physician Physician/Medicai the Due to (or es e consequence of) use as ettending 0 23b. Did tobacco usa contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 94 detech signed by 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peed page 2 1 Yes 2 No 1 Yes 2 THE certificate Division of Vital Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifica director, Be 25. Wes case referred to predical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Besidence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA funeral Certification: 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 PNeturel 5 Pending Injury 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homleide edicai 29e. Certifier 🕒 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner es steted. (Check only one) 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. within 2 To the 29d. Dete signed (Month, Dey, Year) 29b. Signature 29c. License number

of person who completed cause of deeth (Item 23e) (Typa, Print)

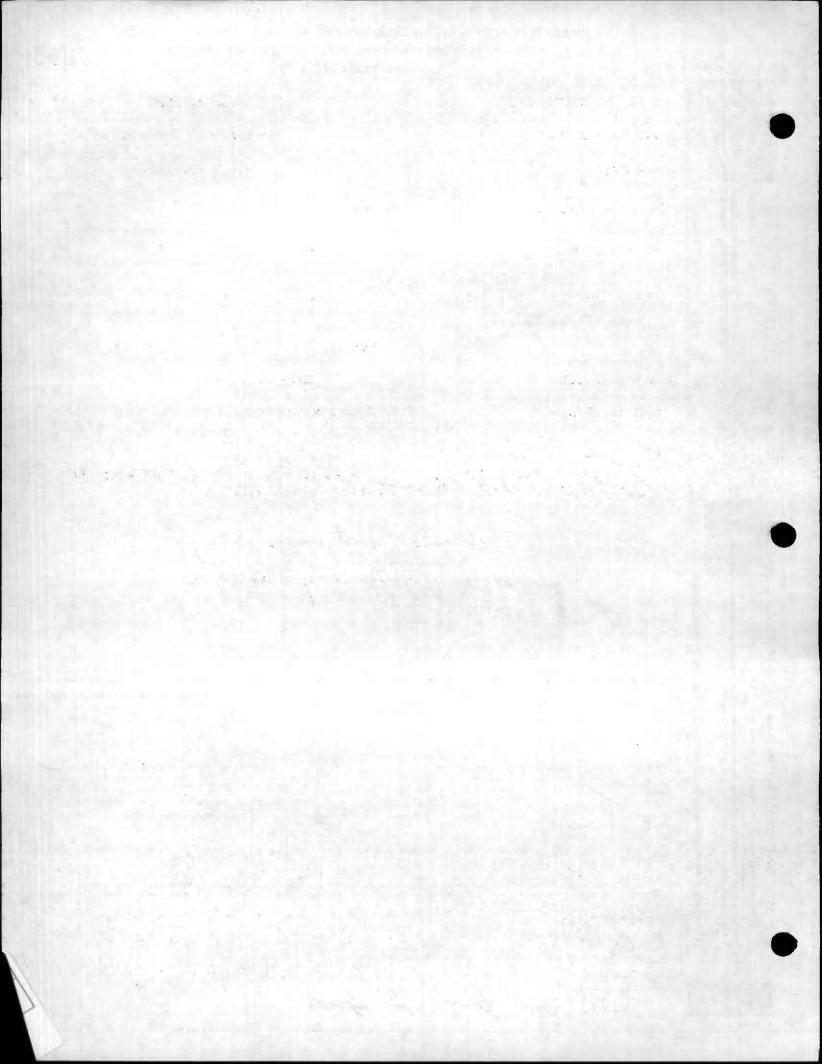
32. Registrer's Signeture

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State Registrar 30. Name end eddre

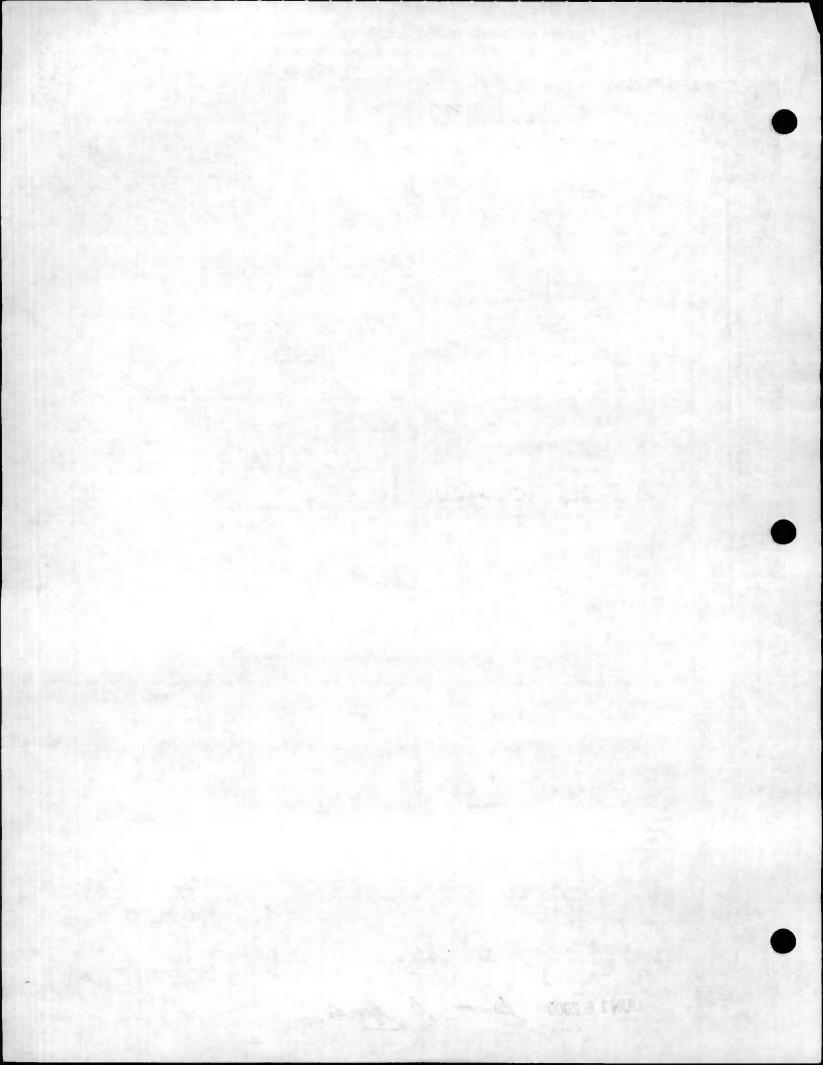
31. Dete filed (Month, Day, Year)

en



ND: I	State of Maryland / Department of Health and TEM# #7 PER F.H. G785 7-12-00 WR. Certificate of Death	d Mental Hy	ygiene ()	0 1	9096
	Decedent's Name (First, Middle, Last)	2. Date of D		Vana	3. Time of Death
nysician	Dorothy Croner	June	11, 2	Year	8:45pm
Medical xaminer	4a Facility Name (If not institution, give street and number) 4b. City. Town,	or Location of Dea		of Deeth	re
	Manor Care Nursing Home Towson  5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year   If Under 24 F				
neral ector		8. Date of B (Month, L 12-1	9-09	Coun	lace (State or Foreign try) MD
4	10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
for must be notified at	MD Baltimore Towson				1 ☐ Yes 2 ☐ No
Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of V	What Coun	try?
y a	417 Railroad Avenue 21286	10	USA	a - Americ	an Indian
Examinar must by Funeral	11. Marital Status  12. Was Decedent Ever In U,S. Armed Forces?  1 □ Never Married 2 □ Married  3 ₺ Widowed 4 □ Divorced  12. Was Decedent Ever In U,S. Armed Forces?  1 □ Yes 2 ₺ No If Yes, Give 1 □ Yes 2 □ No Specify:  1 □ Yes 2 □ No Specify:	erto Rican, etc.)	Specify	k, White,	etc.
	15. Decedent's Education 18a. Decedent's Usual Occupation		16b. Kind of Bu		
Completed	(Specify only highest grade completed)  (Give kind of work done during most of life. DO NOT use retired)  (Give kind of work done during most of life. DO NOT use retired)	working			
Con	6th Grade NA Housewife		in ho		
Be	ml		le, Maiden Suman		
To	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Grace	Johnso		Codel
	19a. Informant's Neme/Reletionship (Type, Print)  19b. Mailing Address (Street and Number of				2178
	Genevieve Cooper 414 Railroad Aven  20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location	City or To	own, State
	*O'Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  **Community or other place)  **Pleasant Rest Cemete**	rv 06-1	7-2000	Tows	son MD
	21. Signeture of Funerel Service Licensee 22. Name and Address of Facility				
			. North		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause on each line.				Approximate Interval Between
음	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or es a consequence of):  d.	ler a	CHA	con	
<u>C</u>	Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h DI	d tohacco use co	ntribute tr	the cause of death
by Physician/Me	Serve duorder		□ Y•• 2 No		bably 4 Unknow
Completed	Lenkopenia	24a. Wa	as an autopsy rformed?	8V CO	ere autopsy findings ailable prior to mpletion of ceuse death?
Con		10	Yes 2 No	1[	Yes 2 No
Be	ayaminar?	Death (Check only	y one)		
70	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursin		sidenca 6 Oth		y)
tion:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (28b. Time of fnjury Work?  1 Accident investigation  M M M	zea. Describ	e how injury occur	100	
Certification:	2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location City or 7	(Street and Numb Town, Stete)	ber or Rure	al Route Number,
edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the complete of the comple	aca, end due to the	ne cause(s) and me e, dete and place,	anner as s and due te	tated. o the cause(s)
₹	29b. Signature and little of partition 29c. License number		29d. Date signe	d (Month,	Day, Year)
Medical Certifi	MAGMMED ALMED D44	796	6-1	3.0	0
IN	1 9512 HAR FORD RA RAITIMARE	- Mr	1757	2	11
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	, 0,0		7
gistrar	JUN 1 6 2000 Brown & Sparks				
6/95					

**ORIGINAL** 



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 91197 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Koland Conaway June 14 2000 7:30 AM - /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Itospital City Baltimore City Mercy Baltimore If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months Days XXM 2 F 71 Yrs Director 219-18-2231 03-12-28 MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other trsumetic event, the Medical Examiner must be notified at TYTYES 2 No MD NA Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1223 Ashland Avenue 21202 death v Funeral USA Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Biack, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural; or ite any Injury or other traumatic event, the Medical Essamine. 1 Nevar Married 2 Married XXYes 2 No It Yas, Giva Year or Dates: 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: py 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) 9th Grade College (1-4or 5+) Maryland Gen. Hosp. NA Porter 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Tomlim Robert Conaway Annie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 19a. Informant's Name/Relationship (Type, Print) Mary R. Conaway 1223 Ashland Avenue Baltimore , Maryland e of Disposition (Nama of Date 20c. Location - City or Town, State M 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition MD. 1 Burial 2 Cremation 3 Removal from State Garrison Forest VA Cem. 06-20-2000 Owings Mills 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerei Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 for WM.C. March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Approximate Intarval Between Onset and Daath **Physician** Immadiata Causa (Final disease or condition resulting in daath) /Medical Chronic Obstructive Pulmonory Disease 20 years Examiner Due to (or as a consequence of): Examiner physicien end as the bunal-trans Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): certificate be execu Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Noninsulin Dependent Diabetes à 24b. Were autopsy findings availabla prior to completion of cause of death? Completed 24a. Was an autopsy Coronary Arkry Disease 1 Yas 2 No 1 Tyas 2 No Division of Vital Be 25. Was case referred to medical 26. Piaca of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 S Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: 5 Panding Investigation 1 Naturai Injury death. 1 ☐ Yes 2 ☐ No i or Attendi after death Director: A 2 Accidant 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State) 4 T Homicide To the Hospital of writing 24 hours a To the Funeral D edical 29a, Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred et the time, data and placa, and dua to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and unner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. Licanse number

State Registrar

DHMH 16 Rev 6/95

ie and address of perso

no completed cause of death (Itam 23a) (Type, Print)

32. Registrar's Signatura

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Baltimore Maryland

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 19098						_
State of Maryland / Department of Health and Mental Hygiene 00 1909	Certificate of Death		00	1 )	U.	) (
	tate of Maryland / Department of Health ar	nd Mental Hygiene	nn	19	00	2 6

wa	ard M. (	lla	rk		S	itate of	Maryla					lealth and l Death	Mental Hy	/giene Reg. No.	00	19	1098
			1. Decedent's Ner	ne (First, Middle	(Last)						-		2. Date of D	eeth			ime of Death
	Physici /Medic			Edwar	d Ma	rnell	Clark	2					June	Day 14	20		58 A.M.
	Examir		4a Facility Name	(If not Institution,	give stre	et and num	nber)					4b. City, Town, or	Location of Dee	th 4c. C	County of D	eath	
ſ			3006 Sr	pice Bus	h Ro	ad						Laure]		An	ne Ar	rundell	
	Funeral Director		5. Sociel Security 403-36-23		6. Sex 1 💢 M	2□ F	7. Age (In yr		thday)_ Yrs.	If Under 1 Months	Year Deys	If Under 24 Hrs Hours Min.			9. S	Birthplece (S Country) entuck	State or Foreign
	D		Usuel Residence				1										
	ier death with the Marylan frems 23s or 28s-f show inst must be notified st	Director	MD MD	10b. County  Anne	Arun	del		city, Town								10	side City Limits  ☐ Yes 2/☐ No
	vith th	吉	10e. Street and No							10f. Zip C		Section 1		10g. Citize	en of What	Country?	
	23a			Spice					1			0724			USA		4
020	8 0 E	by Funeral		ried 2∑ Merrie		Was Dece Armed For 1 X Yes If Yes, Give Year or De	2 □ No e	U,S.	If	/as Decede Yes, specif	y Cub	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)			merican Ind Vhite, etc. White	
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Maryland 21215-0020	10 To be	Completed by	Elementary/Sec	cify only highest condary (0-12)	-	College (1-	4or 5+)		life. D	er/Op	retire		nking	Pa	intin	a	
B	be filed Ital Hygie of other event, n	Bec	17. Fether's Name	(First, Middle, L	ast)							18. Mother's Na	me (First, Middle	e, Maiden S	umame)		
<u>lar</u>		ToE	Haro	old Edwa	rd C	lark						Id	a Marjo	rie Pi	ittma	n	
an	2 should and Menie marke		19e. Informent's N	lame/Relationsh	ір (Туре,	Print)		19b.	. Malling	Address (	Street	and Number or R	ural Route Num	ber, City or	Town, Stat	te, Zip Code,	)
	Health Health om 27 i		Katherin	ne M. Cl	ark/	Wife		30	006	Spice	Bu	sh Road,	Laurel	, Mary	yland	, 2072	24
Baltimore,	2002			sposition Cremetion 5 Other (Sp		oval from S	State	cemeter	y, crem	ition (Name atory or oth	er pla		Dete 6/19/00			or Town, Si	
Ba	Department Department Important: Il important: Il ony injury o		21. dignature of F	micle	complicati	ions that ca	MO1] aused the deach line.		31	3 Tall	bot	ess of Fecility D t Avenue ng, such es cardia		l, MA		d, 207	
	/Medical Examiner	ler.	Immediate Ceuse disease or conditi resulting in death)	on	a	Cont	Due to	hotg.	UN	Ubu.	nd	of Che	est			1	11.00
ó	cata be executed physician and the burial-transit	Examiner	Sequentially list of any, leading to i cause. Enter Und	mmediete erlying	b		Due to	(or as a c	consequ	uence of):			THE				
x 68760,	n certificata be anding physici use as the bu	Medical	Cause (Disease of that initiated even resulting in deeth)	s	c		Due to	(or es e c	onsequ	ence of):					Т		
.O. Box	for the sat	Physician/M	Part II. Other sign	ificant condition	s contrib	uting to de	ath buf not re	esulting in	the un	derlying cau	use giv	ven in Part t.	23b. Die	d tobecco u	es contrib	outs to the c	csusa of death?
0	that bed b											100	10	Y 30 2	No 3[	Probably	4 Unknown
Records,	e law requires t has been signe ge 2 should be	Completed by	-	***		4								s an sutops formed?	sy 24	available	ion of cause
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Viital		Bec	25. Was case refe	rred to medical	L							26. Place of De	ath (Check only	one)			MATERIAL PROPERTY.
>	ysicien: is certific director,	ToE	exeminer?	] No	Hosp	oital:	npatient 2	□ ER/Ou	tpatient	3□ DOA	Ott	han	Home 5□ Re		Dother (S	Specify) at	t scene
ion of	Affing Ph. Affer thi funeral		27. Menner of Dea 1 Naturel 2 Accident	5 Pending investige	ation	28e. Date o	f injury h, Day Year)	28b. 7	Time of njury	28	c. Inju		Self in			, ,	un wou
Division	2 4 4 5	Certification:	3 Suicide	6 Could no determine		8e. Pleca	of Injury - At ig, etc. (Spe	home, fa	rm, stre		office		28f. Location City or To	(Street and own, State)	Number of	Pural Roughice Bus	te Number, sh Ref
	Hospital 24 hours a Funeral Detaily filled	dical	29e. Certifier (Check only one)	1☐ Certifying 2☑ Medical E	Physicis xaminer:	n: To the I On the be and mann	sis of exami	nowledge	, death	occurred at estigation, i	t the ti	me, date and place opinion, death occ	e, and due to thurred at the time	e cause(s) a	and manne place, and	er as stated. due to the c	ause(s)

State Registrar

30. Name and address of person who compouned cause of deeth (Item 23a) (Type, Print)

29b. Signature and title of partifier

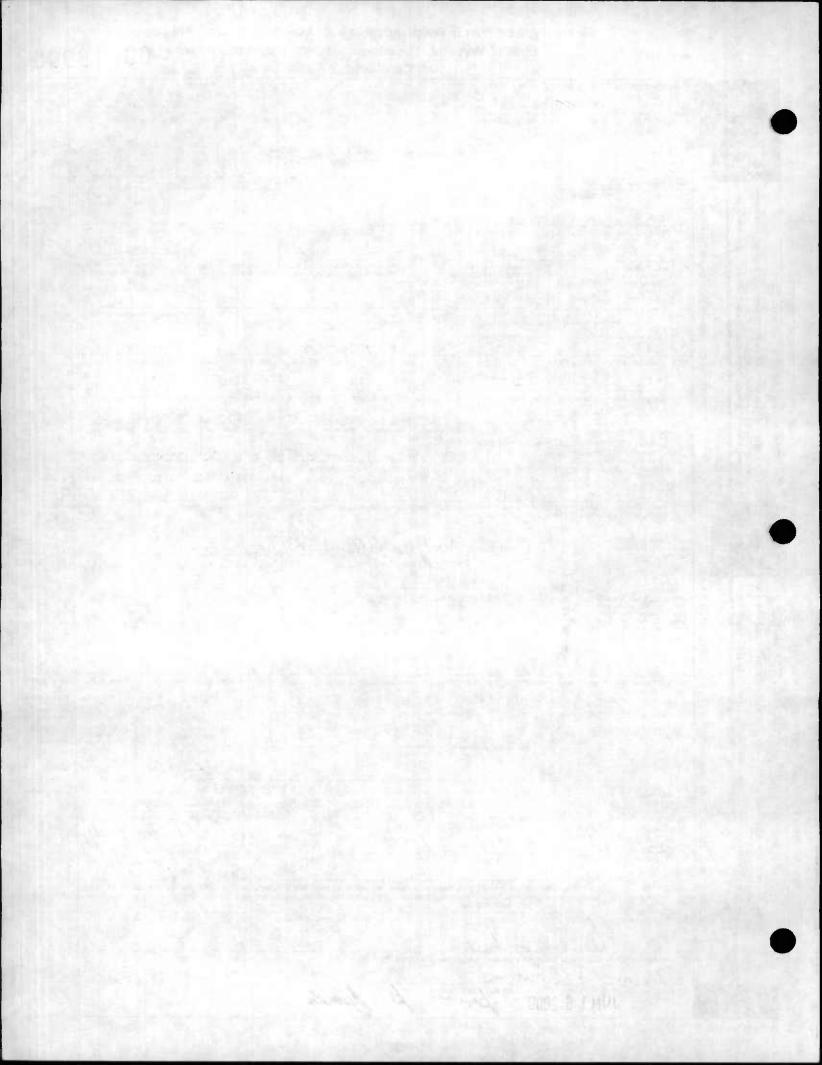
111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 15, 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death JU N **Physician** 4 2000 COSNER TELLA 10: /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Columbia Howard Howard County general Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1□M 2×F Months Days 59 Director 25, Feb. 1941 Virginia 219 48 6817 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If ifem 27 is marked other than "natural" and the traumatic event injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. fnslde City Limits 1 ☐ Yes 24 No **Funeral Director** MD Howard Laurel 10a. Street and Number 10f. Zin Code 10g. Citizen of What Country? 9307 Madison Avenue 20723 IISA Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 3 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8 Home Maker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ed Moore 2 Mary Deal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Luther Cosner/Husband 9307 Madison Avenue, Laurel, Maryland, 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Pk. 6/17/00 Elkridge, Maryland 21. Signature 22. Name and Address of Facility Donaldson Funeral Home, P.A. MOO773 313 Talbott Avenue, Laurel, MD 20707 23a. Part1. Enter the disbase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner attending physician and for use as the bunal-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Box 68760. physiclan Completed by Physician/Medical Due to (or as a consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other efunificant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vitai Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24e. Was an autopsy performed? peen completion of cause of death? After this certificate has 2 12 No 28 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA luneral 28d. Describe how injury occurred 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Division To the Hospital Community within 24 hours after death.
To the Funerel Director: After Tomerel Director of the Turneletaly filled in by the fur 1. Netural 5 Pending investigation 1 Yas 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 29a. Certifier 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) end manner as stated. (Check only 2 Medical Examiner: On the basis of examiner and manner stated. minetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, end dua to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000

**DHMH 16 Rev 6/95** 

State

Registrar

10724

31. Date filed (Month, Day, Year)

Print)

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30. Name and address of parson who completed cause of death (Item 23a) (Type)

JUN 1 6 2000

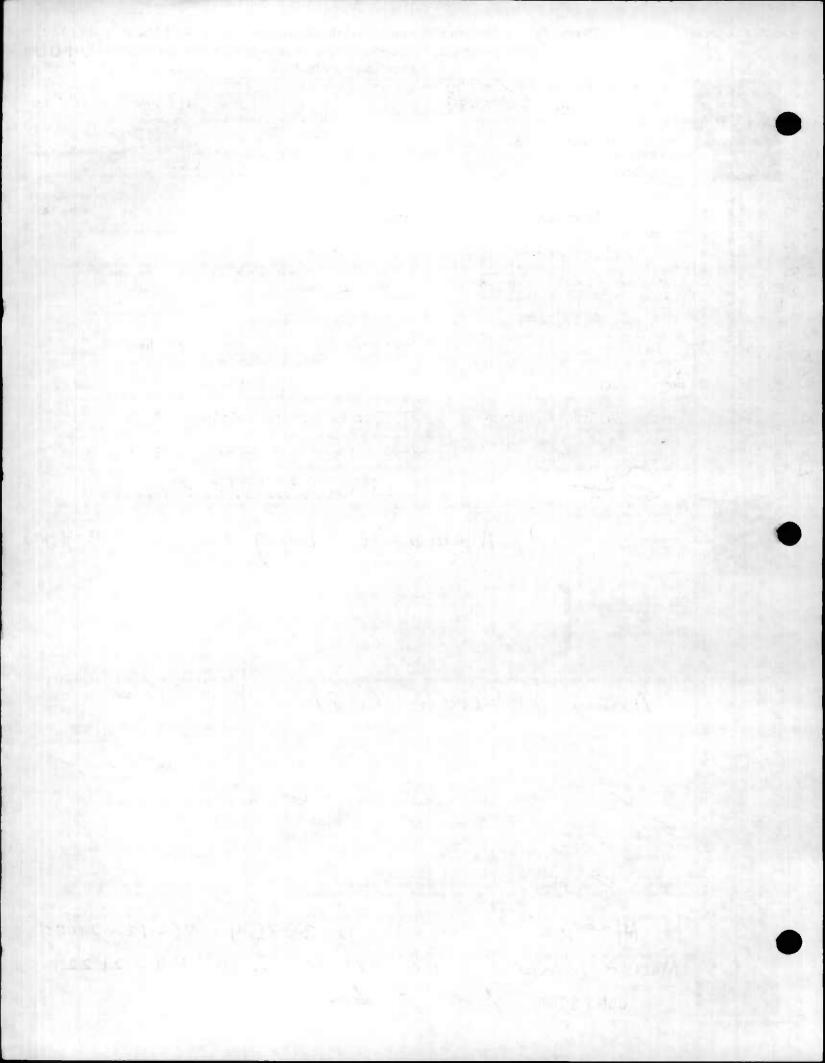
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32. Registrar's Signature

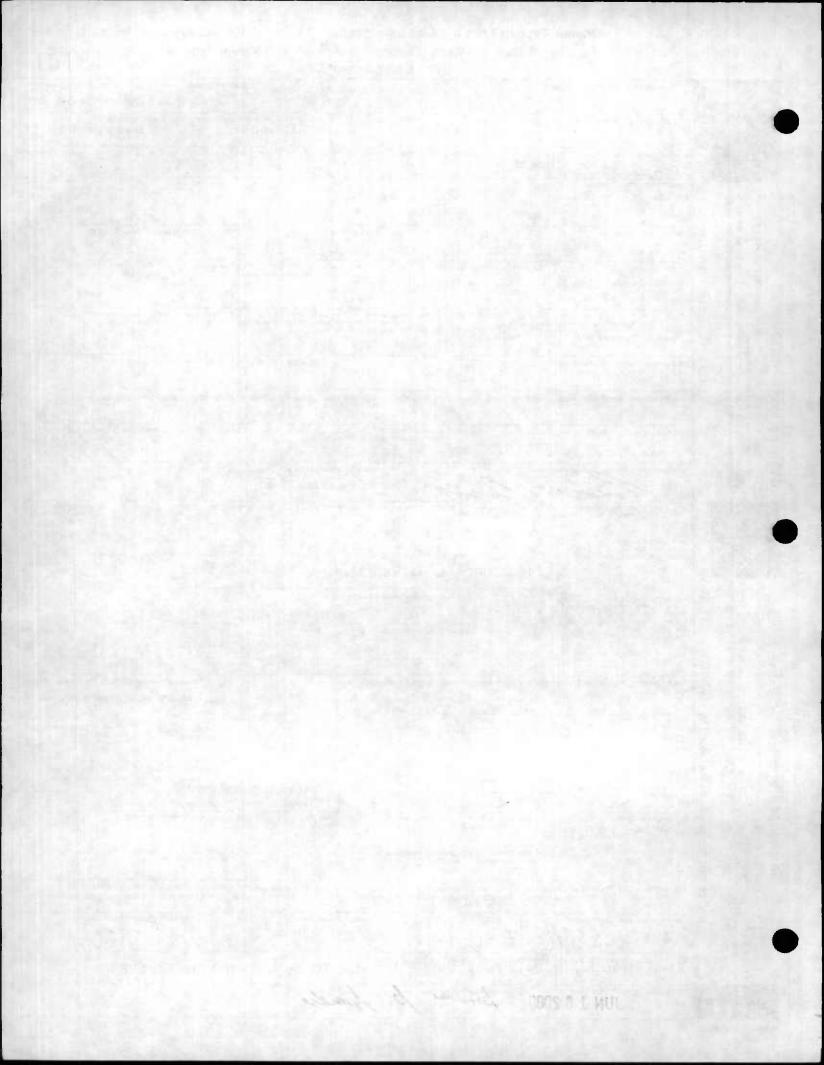
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ore.	of Health of Health Nem 27 r other t		20a. Method of Disposition		20b. Place o	of Disposi	ition (Nama of atory or othar pla	ice)		Data	20c. Location -	City or T	own, Stata
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State of Maryland / Department of Health and Mental Hygiene

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or 28a-f s be notified Director	10e. Streel and Number			THOLI	10f. Zip Coda				10g. Citizan of	What Coun	try?
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or: Af the fu	2 Accidant Investiga	tion		,,		☐ Yes 2 ☐	No				
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Med Med	29b. Signature and title of certifier	and manr	nar stated.		29c. Lica	nsa number			29d. Data signi	ed (Month,	Day, Year)
	1-11	1. 4	4.1 N	1.0	1000	034		0.01	6/1	2/1	1
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F 8	30 Name and address of parson of	ho completed seve	e of death (leas	n 23a) (Tuno	Print)				0(1	5/01	J
2()	3p. Name and address of person w	no completed caus	e of death (Item	23a) (Type,	Print) RIVE,	TOWSO	IN,	MARYLA	AND 21	204	J



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12 2000 Month JUNE **Physician** 3:40am Stanley Frederick Dederer /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1MM 20F Director 218-34-1437 62 Feb 4, 1938 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Cockeysville Nume 23a or 28a-4 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 10114 Daventry Drive Funeral 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1955-63 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 04 Postal Service Executive U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked C. Dederer, Sr. Esther Stamm 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Hem 27 h Lesley I. Dederer / Wife 21030 10114 Daventry Drive, Cockeysville, MD altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns. 6/15/00 Timonium, Maryland 21. Signature of Fungs 22. Name and Address of Fecility Lemmon Funeral Home Michael J Flagle 10 W. Padonia Road, Timonium, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical fmmediate Cause (Final disease or condition resulting in deeth) Examiner Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last RRHO Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown b 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was cese referred to medical axaminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 this funeral 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After t 5 Pending investigation s after death.

I Director: Aft
of in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide To the Hospirar To the Funeral Director To the Funeral Director To the Funeral Director To the Funeral filled in D 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homlcide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) and menner es stated.
2 Had cal Examinar: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifier beodor wo 30 Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

State Registrar

KOCTE

31. Dete filed (Month, Day, Year)

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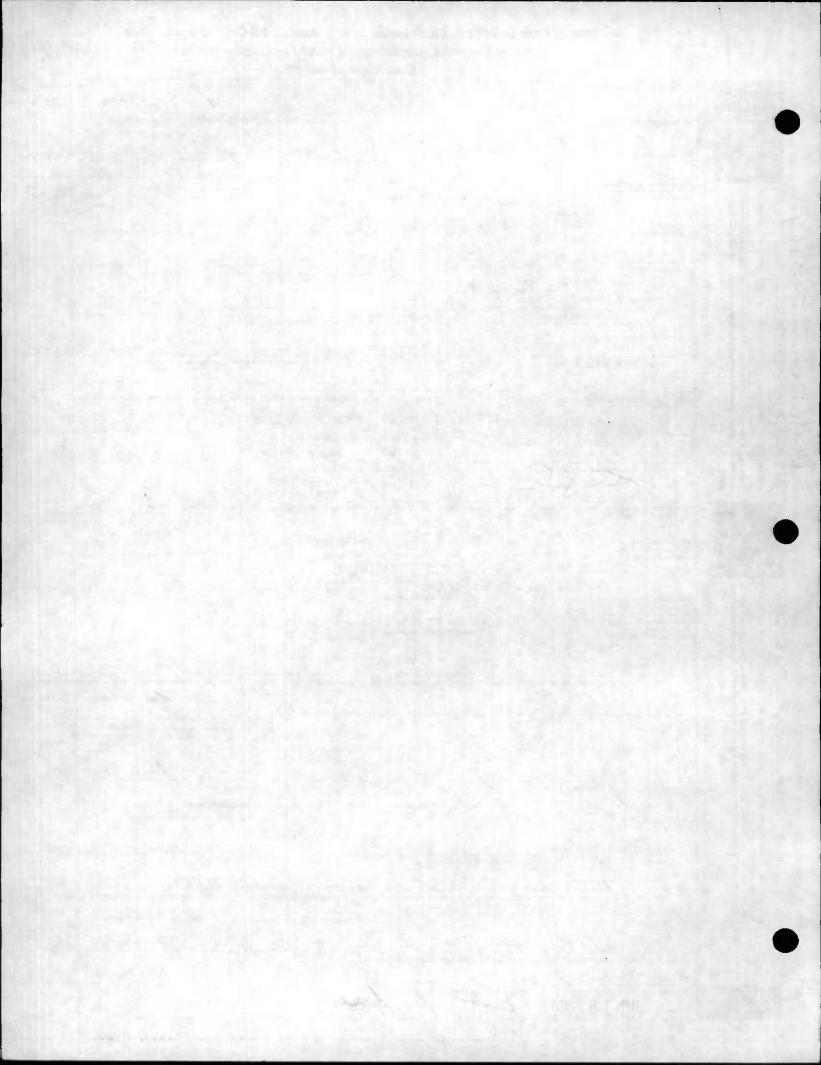
JUN 1 6 2000

**DHMH 16 Rev 6/95** 

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32. Registrer's Signeture

N.CHARLES STREET BALTO MD21204



				Ce	пінсац	e or i	Death		Reg. No.		
Physician	1. Decedent's Name (First, Midd		ac TI	DA	11.50			2. Date of D Month	Death Day	Yaar	3. Time of Death
/Medical	JENNIFER	ELIZA	H (3C)	UA	G-G- E 1			June		1000	3:45 P
Examiner	4a Facility Name (If not institution							, or Location of Dea		County of Death	
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Funeral	5. Social Security Number		Age (In yrs.	last birthday)	ff Under Months	1 Year Days	If Under 24 Hours	Hrs. 8. Date of B	Birth Dev. Yeer)	9. Birth	place (State or Foreign
Director	099-70-8573	1□ M 2□XF	15	Yrs.		,-		9-20-			yland
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Sire Sire	10e. Street and Number				10f. Zip					en of What Cou	ntry?
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by Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U	,S. 13.	Was Deced	lent of H	lispanic Origin	? (Specify Yes or November 1)	10- 14	I. Race - Americ Black, White,	
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و	3 □ Widowed 4 □ Divorce	Year or Date			100 2	22.100	ороспу.		3	Specify: Wh:	ite
Completed		nt's Education est grede completed)		16a. Dece	dent's Usua	l Occup	ation during most o	f working	16b. Kind	d of Business/In	dustry
n di	Eiementary/Secondary (0-12)	College (1-4	lor 5+)	life.	DO NOT us	e retired	3)				
Ö	10	Ø		N/A						N/A	
Be	17. Father's Name (First, Middle	Last)					18. Mother's	Name (First, Midd	le, Maiden S	umeme)	
10	David J. Dagge	r					Vero	nica Fran	cis		
-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address	(Street	and Number	or Rural Route Num	ber, City or	Town, Stete, Zij	Code)
	Veronica Franc	is moth	ner	909	2 Cher	rry	Lane L	aurel, Ma	rylan	d 20708	
	20a. Method of Disposition		20b. F	Place of Dispo	osition (Nem	ne of	201	Date	20c. Loca	ation - City or To	own, State
	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		ate	y <b>H</b> 111				6-18-00	Ralt	imore	Maryland
	21. Signature of Funishal Sequipe					-	ss of Facility	0 10 00	Date	Imore,	rialyland
SUCE.	Jan & Back	2000	in					me Inc.			
	The state of the s	8 mai	142	7	601 Sa	andy	Sprin	g Road La	urel.	Maryla	nd 20707
	hock, or heart failure. Lis	r complications that cau	sed the deat	th. Do not en	ter the mode	e of dyin	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
an 🖊	to survivore of poor										Onset and Death
cal	tmmediate Cause (Final disease or condition	R	ESPII	RATOR	RY	FAI	LURE				DAYS
er	resulting in death)	a		or as a conse		,	3 10 10	100	7-1-2		
를		P	NEUN	NONIA	4						DAYS
E	Sequentially list conditions.	0.		or as a conse	-						
Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		SEPSI								DAYS
cai	Cause (Disease or Injury that initiated events	C	-	or as a consec	quenca of):						
n/Medicai Examiner	resulting in death) Last	-		c FI							YEARS
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Jys			III OUL HUL FØS	oung in the t	woorlying C	ause giv	will raff.			,	
7	RENAL FA	ILLIRE							Yes 20	No 3□ Pro	bably 4 Unknown
Completed by Physicia								24a W	as an autops	24b. W	/ere autopsy findings
ete									rlormed?	an CC	vailable prior to empletion of cause
du										of	death?
S								10	Yes 212	No 1	□Yes 2M No
Be	25. Was case referred to medical examiner?							Death (Check only	y one)		
2	1 ☐ Yes 2 No	Hospital: 1 King	patient 2	ER/Outpatie	nt 3□ DO		4 Li Nuis	ing Home 5 ☐ Re	sidenca 8	□Other (Speci	ity)
Medical Certification: To Be Com	27. Manner of Death 1 Naturel 5 Pendi	28a. Date of (Month,	Injury Day Year)	28b. Time o	of 2	8c. Injur Wor	y at k?	28d. Describ	e how injury	occurred	1-1-1-1
atic	2 ☐ Accident invest	igation			М		Yes 2□No				
E S	3 Suicide 6 Could	nined   288. Place 0	f Injury - At h	ome, farm, st	reet, factory	, office			(Street end own, Stete)	Number or Rur	al Route Number,
Certification:	- Livinous	building	, etc. (Specii	7)				Only of 1	J, D.(010)		
ai C	29a. Certifier 1 Certifyi	ng Phyeician: To the be	est of my kno	wiedge, deat	h occurred a	at the tin	ne, date and p	place, and due to th	ne cause(s)	and manner as	stated.
Medicai	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examina	ation and/or In	vestigation,	In my o	pinion, death	occurred at the time	e, date and p	placa, and due t	to the cause(s)
No.	29b. Signature and title of certific		-		29c	. Licens	e number	111111111111111111111111111111111111111	29d. Date	signed (Month,	, Dey, Year)
	1/	-1A-11	1			00	5 -00	0			
	Will	14/8/1	my			RE	-00		JUN	E 14, 3	2000
	30. Name end eddress of person										
	WILLIAM	H. STOT			EDIAT	RIC	INTEA	VSIVE CAR	E JH	IH BAI	LTIMORE, mi
State	31. Date filed (Month, Dey, Year	32. Reg	istrar's Signa	ature /	/	•	/				

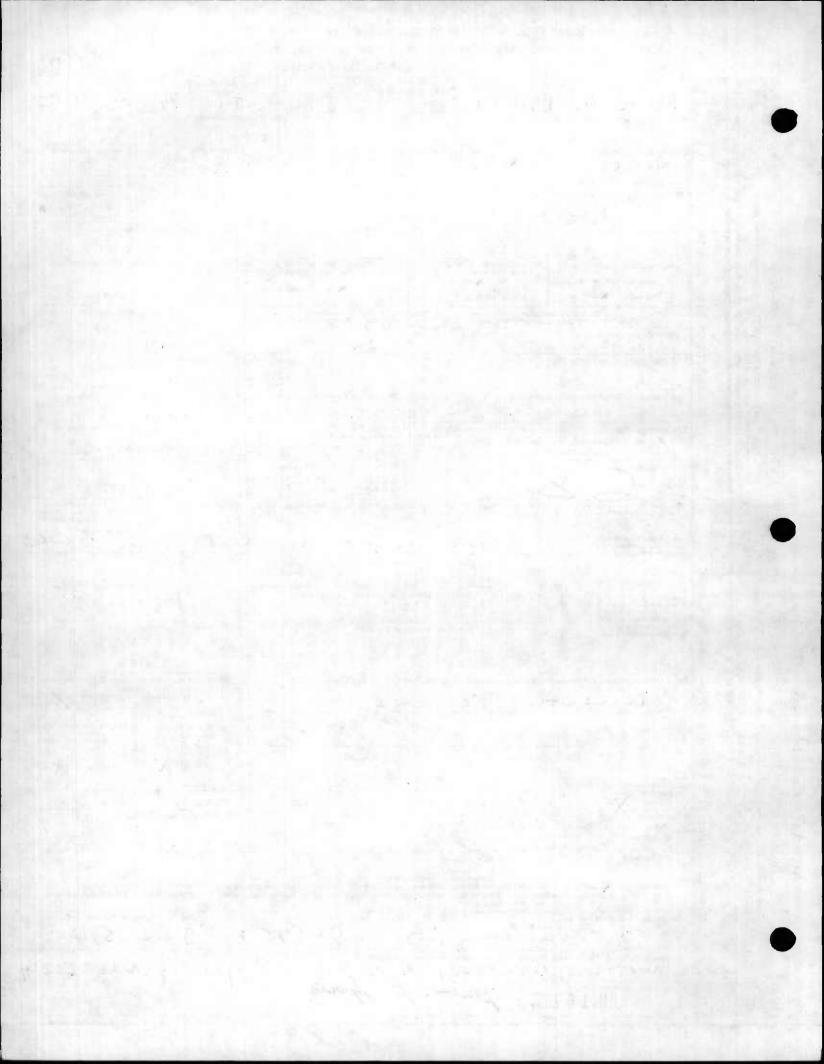
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Registrar

JUN 1 6 2000

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month A. Marie JUNE 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Eastpoint Nursing Home Eastpoint Baltimore H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-22-05 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Days Yes 212-03-3386 94 Director MD Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle ed other than "natural", or flems 23s or 28s-f show event, the Medical Examinar must be notified at 1 Ti Yes 2 No Director Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8325 Philadelphia Road 21237 USA 12. Was Decedent Ever in U,S. Armed Forces?
1 □ Yes 2 輕 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours efter of Hygiene. Other than "natural", or her 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 M Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Clerk 0 permit. Peges 1 and 2 should be file Department of Heelth and Mantal Hy Important: If Item 27 is marked other eny Injury or other treumatic event, ables. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Barbara Havrenek John Silver 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8325 Philadelphia Road, Baltimore, MD Lillian Silver/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Buriat 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cem 6-17-00 Baltimore, MD 21. Signature of Funeral Service Ligar 22. Name and Address of Facility Cyach/Rosedale Funeral Home 1211 Chesaco Avenue, Baltimore, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Accident /Medical Cerebravas mulas Examiner Due to (or es a consequence of): ettending physicien and for use as the burlel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not restricting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Ser ? wes certificate has been si-lirector, page 2 should I Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 2 NNO 1 Yas 2 No 1 Yes of Attending Physicien: efter deeth. Director: After this certifica 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. tnjury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral D completely filled I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45757 JUNE 15, 2000 M. Whelee 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Jopans Bayvers Circle 21224 MATLEW MCNABNEY 32. Registrar's Signature 31. Date filed (Month, Day, Year)
JUN 1 6 State 2000 Registrar

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 00 19105

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Fune	ral	5. Social Security Number	6. Se	x 7.	. Age (In yrs. la	st birthdey)	If Under		If Under Hours		8. Dete of Bir (Month, De	h v Year)	9. Birthe	olace (Steta	or Foreign
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27 E		Vera M. DiPaol	a /	Wife		56	13 Be	nto	n Heig	ghts	Ave. I	Baltimor	e, M	D 21	206
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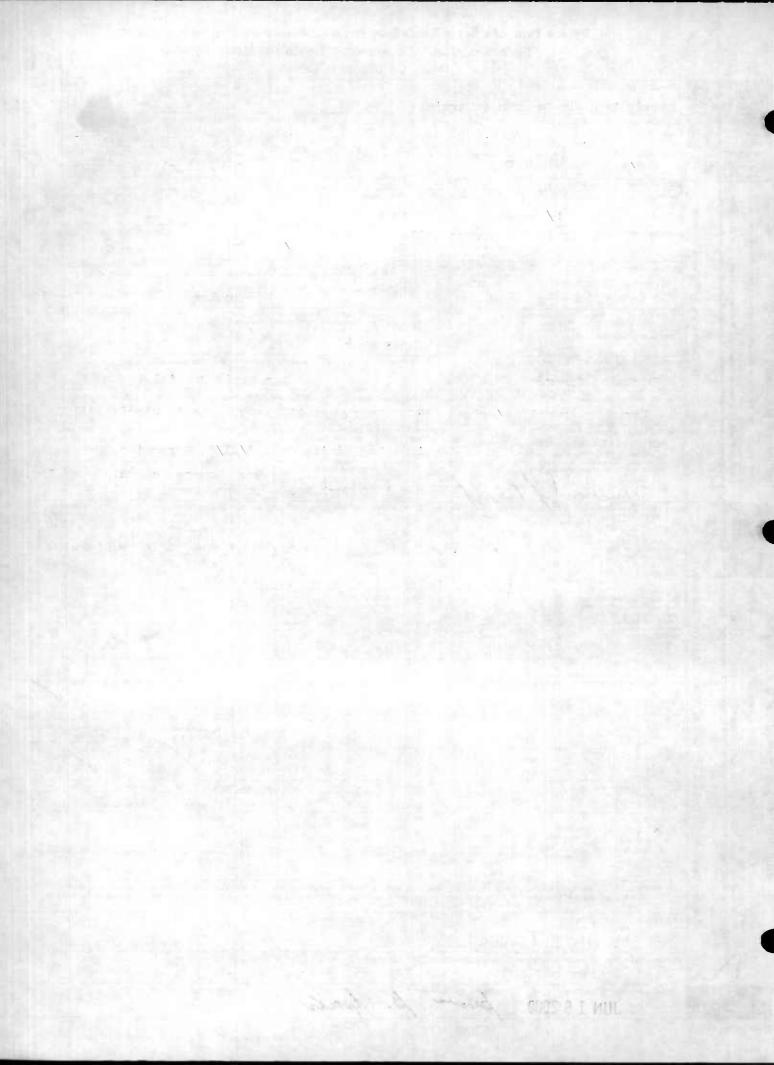
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Neria Lourdes Martinez

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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene [] []

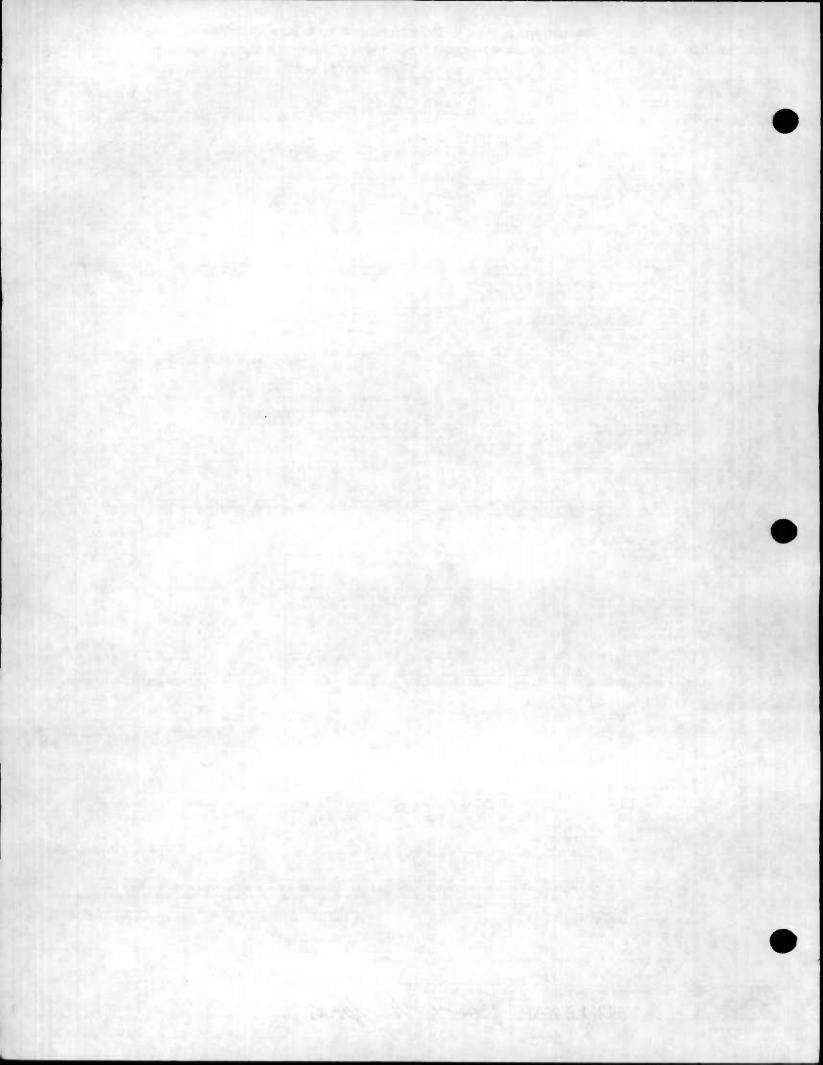
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MARVIN EDWARDS Certificate of Death AMEND ITEMS: #23 PART I, 27 PER MEO G784 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Year **Physician** Marvin Edwards JUNE 12 2000 10:46 AM /Medical 4c. County of Deeth 4a Facility Nama (ff not Institution, give street end number) 4b. City, Town, or Location of Death Examiner GREATER LAUREL BELTSVILLE HOSPITAL LAUREL PRINCE GEORGES If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min. 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Months XXM 2□ F 219-78-1979 Yrs. 39 Director 09-18-60 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Marylat 28a-f show the Medical Examiner must be notified at 1 yas 2 No Director MD NA Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? lierna 23a or 3827 Monteray Road 21218 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Black, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lt Yes, specify Cuben, Mexican, Puerto Rican, etc.) hours after 1 Nevar Married 2 Merried b Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Slad within 72 al Hygiene. Elementary/Secondary (0-12) I2th Grade NA College (1-4or 5+) Welder National Steel Co. 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Mental 8 Jeremiah Edwards Vermell Dargan Pages 1 and 2 should Brid F m 19b. Melling Addreas (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21218 19a. Informant's Neme/Reletionship (Type, Print) frem 27 is Vermell Edwards 3827 Monteray Road Baltimore, Maryland Saltimore, 20b. Plece of Disposition (Neme of cemetery, crametory or other plece) 20c. Location - City or Town, State MD. 20a Method of Disposition Dete Department of h Important: If its Buriel 2 ☐ Cremetion 3 ☐ Removet from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville VA Cemetery 06-16-2000 Crownsville 21. Signatura of Funaral Service License 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tellure. List only one cause on each line. Approximata Intervat Between Onset end Death **Physician** PULMONARY THROMBOEMBOLISM /Medical immediate Ceuse (Finet DEEP VEIN THROMBOSIS OF RIGHT LEG disease or condition resulting in deeth) Examiner Due to (or as a consequence ot): Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immadiete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and Due to (or as e consequence ot): physician s the burial Box 68760 Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. P.O. signed by t 1 Yes 2 No 3 Probably 4 Winknown ATHEROSCLEROTIC CARDIOVASCULAR DISEASE þ of Vital Records, 24a. Was en autopsy performed? 24b. Wera autopsy tindings available prior to pege 2 should Completed peed complation of cause of death? is certificate hes director, page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Wes case reterred to medicat examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ €R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Mennar of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After Division 5 Pending investigation 1 Neturet 1 Yes 2 No apital or Attenditions after death. death. 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicida 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certities Une O.C.M.E. JUNE 13, 2000 30) Name and address of person who completed cause of death (Item 23a) (Type, Print) KOROL 111 Penn Street, Baltimore, Maryland 21201 31. Data filed (Month, Dey, Year) 32. Registrer'a Signature State Registrar **JUN 1 6** 2000

**DHMH 16 Rev 6/95** 

**ORIGINAL** 



					State of Marylar	Certificate		viciliai i iy	Reg. No.	19108
		Physic	ian	1. Decedent's Neme (First, Middle,	Last)			2. Date of De Month	Day	Year 3. Time of Death
		/Medi Examir		4e Facility Name (If not institution,	JMGE give street and number)		4b. City, Town, or I	ocation of Deal		of Deeth
		=Xarrar		Stella Ma	Ris Hospice		Timoniu	m	Bal	timore
	L	Funeral Director		5. Social Security Number  212-10-9772  Usual Residence of Decedent	5. Sex 1 1 1 A M 2 □ F 7. Age (In yrs.	185 Yrs. If Under 1 Months	Year Munder 24 Hrs.  Deys Hours Min.	8. Date of Bi (Month, D	rth ay, Year) 7 19/5	9. Birthplace (State or Foreign Country) Maryland
15, 2000 9:22 a.m.		permit. Peges 1 and 2 should be filed within 72 hours a begartment of Heelth end Mental Hygiena.  Important: if Item 27 is marked other than "natural", or or or any injury or other traumatic event, the Medical Exp.	_	10a. Stete 10b. County	10c. Cit	ty, Town or Location	-			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	21215-0020		recto	10e. Street and Number	imore po	LEKVILL 101. Zip C	Code		10g. Cifizen of V	
			ral Di	3034 MORE	land Ave.	á	11234		US	4
			by Funeral Director	11. Merital Status  1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Detes:	13. Wes Decede If Yes, specif	nt of Hispanic Origin? (Si y Cuban, Mexican, Puert XNo Specity:	pecify Yes or No Rican, etc.)	Specify	e - American Indian, k, White, etc. :: White
			To Be Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Decedent's Usual (Give kind of work	Occupation done during most of work retired)	king	16b. Kind of Bu	usiness/Industry
	212			Elementery/Secondery (0-12)	College (1-4or 5+)	Machine	retired)		Copper	corp.
				17. Father's Neme (First, Middle, La	ist)	· · · · · · · · · · · · · · · · · · ·	18. Mother's Nerr	ne (First, Middle	, Maiden Surnam	e)
	Maryland			19a. Informent's Neme/Reletionship	1GL p. (Type, Print)	19b. Mailing Address /	Street and Number or Ru	LILT	OF City or Town.	State, Zio Code)
				William En	IGL SON	8420 Q	ak. Rd. Bi	altimo	SRO Ma	121234
	Baltimore,			20e. Method of Disposition 1 Ø Burial 2 ☐ Cremetion 3	Removel from Stete	Plece of Disposition (Name cometery, cremetory or oth		Julie 19	20c. Location -	City or Town, Stete
JUNE	altin			4 ☐ Donetion 5 ☐ Other (Spe 21. Signeture of Fundral Service Lie		22. Neme end	Address of Fecility	2000 F	Parkvi	Change
5	Ö			Xeista.	I. adolls	28800	HARFARD R	& Bal	HIMARO	Md 21234
				23a. Fart Enter the disease, or co shock, or heert teilure. List or	omplications that caused the deat nly one cause on each line.	th. Do not enter the mode	of dying, such es cardiac	or respiretory e	orrest,	Approximate Interval Between Onset and Deeth
				Immediate Ceuse (Finet disease or condition	COLON CANCI	7D				
	п		٥	disease or condition esulting in deeth)  esulting in deeth)  COLON CANCER  Due to (or as a consequence of):						
ISSAC EMGE		•• Hospital or Attending Physician: The law requires that the death certificata be n.24 hours after death. •• Funeral Director: After this certificate has been signed by the attending physicia pietely filled in by the funeral director, page 2 should be detached for use as the bur	Examiner	b						
	s, P.O. Box 68760,			Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es a consequence of):  Due to (or es a consequence of):						
			Certification: To Be Completed by Physician/Medical	Cause to lead to lighty  C.  Due to (or es a consequence of):  Due to (or es a consequence of):						
				•	d					1
				Pert tt. Other algolificant conditions	contributing to death but not res	ulting in the underlying car	use given in Pert t.			ntributa to the cause of death?
								10	Yaa 2∐ No	3 ☐ Probably
	Record							24a. Wes	en autopsy ormed?	24b. Were eutopsy findings available prior to completion of cause
	Division of Vital Rec							10	Yes 21X No	completion of cause of death?
				25. Wes case referred to medical examiner?						TO Yes 20 No
				1 Yes 2 No		ER/Outpatient 3 DOA 28b. Time of 28			idence 6 NOth	
				1 Netural 5 Pending 2 Accident investige	28e. Dete of Injury (Month, Day Year)	Injury M	c. Injury at Work? 1 □ Yes 2 □ No	200. Describe	now injury occur	60
			rtffe	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify)  28f. Location (Street and Number or Rura City or Town, Stete)						er or Rural Route Number,
				29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.						
			Medical	anej	taminer: On the basis of examine end menner steted.			rred at the time,		
				29b. Signature and little of certifier	)0	290.	License number			d (Month, Day, Year)
				30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)						
		Sta	te	DR. TARIQ MAHMO 31. Dete filed (Month, Day, Year)	OOD 2300 DULANE	EY VALLEY RD.	TIMONIUM,	MD 210	193	
		Registr	ar	JUNI	o ZUUU Dere	PA	yours			

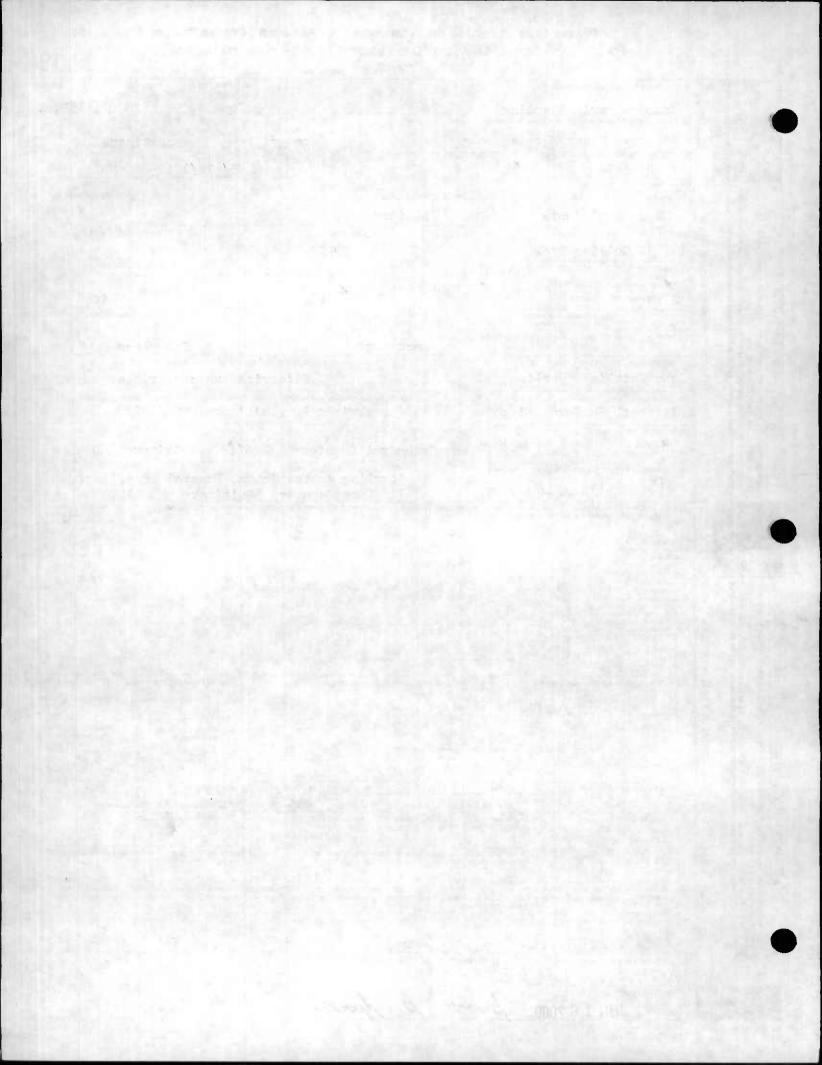
### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's Ner	ne (First, Middle	, Last)		rland / Depa Cer	rtificate of		2. Dete of De	Reg. No.	0 19	109	
n al		Marie	Eberling		- Yer-		4b. City, Town, or Lo	Month June	Dey 3	Year 2000 1:		
	5. Sociel Security 215-01-1	Number L670	Nursing 6.Sex 1□M 2KF	7. Age (I	n <i>yrs. last birthday)</i> 89 Yrs.	If Under 1 Yee Months Days		8. Dete of Bir (Month, De	Balt by, Year) 5/1910	imore  9. Birthplece ( Country)  MD	(Stete or Foreign	
-	Usual Residence of 10a. Stata	of Decedent 10b. County		10	c. City, Town or Lo	cation	DATE:			10d. In	side City Limits	
THE CASE OF THE PARTY OF THE PA	MD	Baltim	nore		Baltin	nore		1	Yes 2 No			
ľ	10e. Street and Nu					10f. Zip Code			10g. Citizen of V	What Country?		
= -	121 S. C	Collins					229		USA		<b>4</b> 1.	
		ried 2 Merri	12. Wes De Armed F 1 1 Yes If Yes, G Yaar or	Forces? s 25 No Giva		was Decedent of if Yes, specify Cul	Hispenic Origin? (Spe ban, Mexican, Puerto I Specify:	Rican, etc.)	Specify	e - Amarican Ind ck, Whita, etc.	oian,	
	(Spe		t grade completed	d) (1-4or 5+)	16a. Deced (Give life.	kind of work done DO NOT use retin	nt's Usual Occupation of of work done during most of working NOT use retired)			16b. Kind of Business/Industry		
	17. Fethar's Neme	(First, Middle, I	Lest)		Decre	cary	18. Mother's Name	(First, Middle	Insura , Maiden Sumen			
	John Got	tlieb E	berling				Catheri	ne Fran	nces Tri	bbe		
	19e. Informent's N Elizabet		nip <i>(Type, Print)</i> ord Niec		1336	Denbrig	ht RD Bal	timore	, MD 212	28		
		•	3 □Removal from	m State	cometery, cres cemetery, cres ew Catheo	netory or other ple		Dete 6/19	20c. Location - Baltimo	city or Town, S	State	
	Immediate Ceuse disease or condition resulting in deeth)  Sequentially list or if eny, leading to icause. Enter Und Cause (Disease of their initiated even resulting in death)	(Finel on	a	Due Due	NEUM O  to (or es e consect to (or es e consect to (or es a consect to (or es a consect to (or es a consect to to (or es a consec	quenca of):  COL quenca of):  uence of):		INCE		D A	roximete vel Between et and Deeth  3 Y S  AR S	
	orth, Other aight				ANCE		iver are est.		Yee 2□No			
Completed by			~		7			24a. Wes	en eutopsy ormed?	svailable	utopsy findings a prior to ion of cause	
								10	Yes 200 No		2 □ No	
	25. Wes case refe exeminer?	rred to medical					26. Place of Deeth	(Check only	one)			
-		M.	1	Inpatient e of Injury	2 ER/Outpatier	IT 3LI DOA			Idence 6 Oth			
	Neturel Accident 3 Suicida 4 Homicide	5 Pending Investig 6 Could n determi	etion (Mo	onth, Dey Ye	At home, farm, str	M 1 [	Yes 2□No	28d. Describe how injury occurred 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
-	29a. Certifier (Check only one)	Certifying	Physician: To the Examiner: On the end ma	ne best of m basis of exa	y knowledge, deeth aminetion end/or in-	n occurred at the t vestigation, in my	time, date end pleca, a opinion, death occurre	and dua to the ed at the tima,	cause(s) and madata and place,	anner as stated. end due to tha	ceuse(s)	
29b. Signature and bite of certifier 29c. License number					nse number		29d. Date signe		Year)			
-	29b. Signature and	this of certifier										
	29b. Signature and	1	anthal	cum	a/MI	D	42510				2000	

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DHMH 16 Rev 6/95

**ORIGINAL** 



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Day **Physician** EPSY E . FEASTER JUNE 08, 2000 0050 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ST. AGNES HOSPITAL NA 8. Date of Birth (Month, Day, Year) 08-16-34 If Undar 1 Year | If Under 24 Hrs. Birthplace (Stata or Foreign Country)
 SC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 10M 20F Months 65 214-40-1405 Director Usual Rasidenca of Decedent the Manyland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits nem z7 is marked other than "natural", or fiems 23s or 28s-f show other traumstic event, the Medical Examinat must be notified at 1 ØYes 2 □ No NIA Funeral Director BALTIMORE MD 10f. Zip Coda 10o, Citizen of What Country? 10a, Street and Number filed within 72 hours after death with 21229 USA N. AUGUSTA AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Maritai Status Black, White, atc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify Specify: BLACK Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Datas: 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CHILD CARE PROVIDER CHILD CARE 12-TH GRADE NIA permit. Peges 1 and 2 should be filid Depertment of Heelth and Mentel Hy Important: If them 27 is marked other any injury or other traumatic events 18. Mothar's Name (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) MARY COLEMAIU FLOYD ENGLISH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) HUSBAND BALTU. MO. 21229 BENJARMIN FEASTER 112 N. AUGUSTA AVE. 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cramation 3 ☐ Removal from State 6.13.00 RANDALISTOUN, MO PARK KING MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility 21. Signature of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter the change or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or have shirten. List only one cause on each line. Approximata interval Batween Onset and Deeth **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Vakaowa Examiner Examiner The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequance of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical Due to (or as a consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributs to the cause of death? signed by to 1 Yes 2 No 3 Probably ♣ Unknown þ 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to page 2 should Completed been complation of cause of death? certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 No if or Attending Physician: after death. 25. Was cesa referred to medical examiner? Be 26. Placa of Daath (Chack only ona) 1 Yas 20 No Hospitai: Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification: To 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this eral Director: After this filled in by the funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Panding investigation 1 Yes 2 No 6 Could not be datermined 28f. Location (Straet and Number or Rural Route Number, City or Town, Stata) 3 Suicida 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completaly filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and mannar as stated.
20 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier Physician Idias 30. Name and addrass of person who completed ceuse of deeth (Item 23e) (Type, Print)

State Registrar

**DHMH 16 Rev 6/95** 

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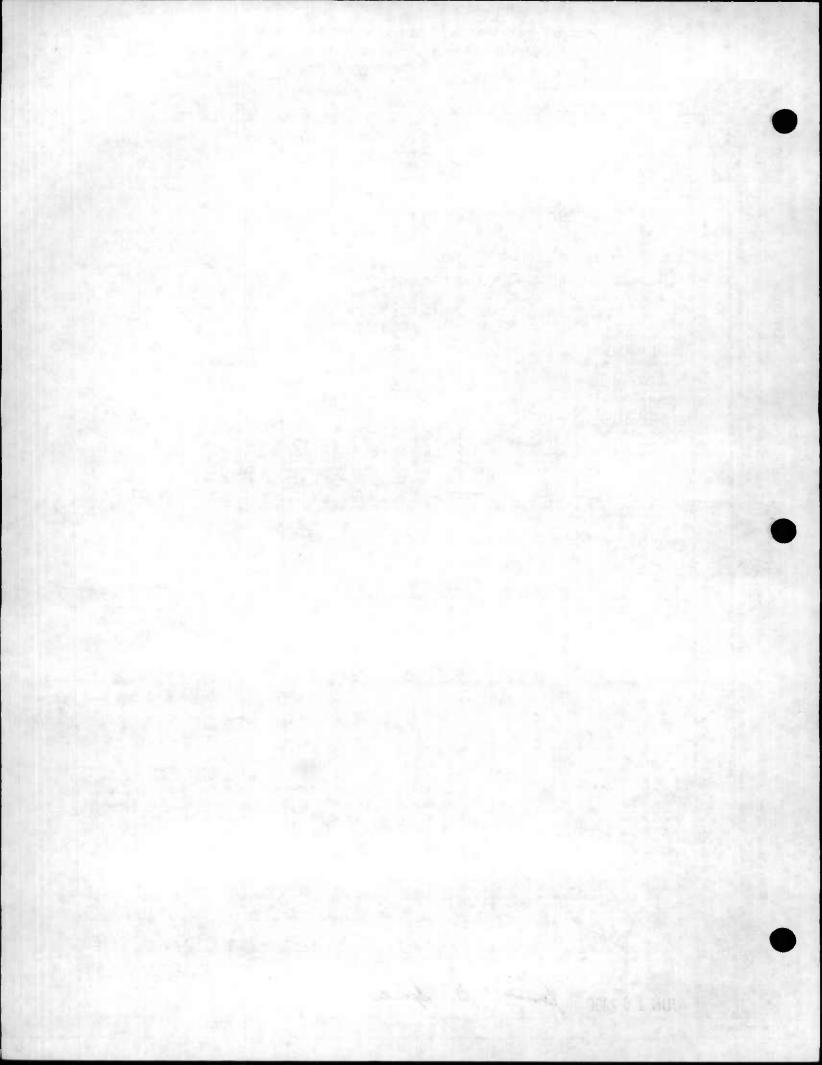
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Unknown 00-153 Salvatore Ferititta, Jr. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Month Yee **Physician** Salvatore Fertitta, Jr. 2000 1:17 A.M June 14 /Medical 4e Facility Neme (ff not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** I-195 under Sulphur Spring Road Halethorpe Baltimore If Under 1 Year | If Under 24 Hrs 8. Dete of Birth (Month, Day, Year) 07/05/1964 5. Social Security Number 7. Age (fn yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys Hours Months 10 M 20 F 35 Yrs. 217-94-8302 Maryland Director Usual Residence of Decedent 10a. Slete 10b. County 10c. City, Town or Location 10d. Inside City Limits show MD Baltimore Arbutus 1 ☐ Yes 2 No Director 28a-f the Medical Exeminer must be notifi 10/ Zin Code 10e Street and Number 10g. Citizen of What Country? Berns 23a or 21227 USA Funeral 4845 Carmella Drive 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married 1 Yes 2 No if Yes, Give 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: White by 3 Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7 is marked other than " Elementery/Secondery (0-12) 12 College (1-4or 5+) Turn Bull Foreman Enterprises 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Department of Health and Mental Important: If New 27 is marked o Salvatore Fertitta, Sr Patricia L. Couch 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 139 Elizabeth Ave. Arbutus, MD 21227 Cheryl D. Fertitta Wife 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removel from Stete Loudon Park Cemetery 06/17 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licent 22. Name end Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue, Catonsville, MD 21228 Approximate Interval Between Onset and Death 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Fal Gunshot Wound Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Examine **burial-transit** The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 physicien Physician/Medical the Due to (or as e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records. P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b þ 24a. Was an eutopsy performed? Were autopsy findings available prior to Completed completion of cause of death? hes 1 No 2 □ No 1⊠Yes 2□ No certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/OutpetienI 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) at scene 1 Yas 2 No Certification: To this funeral 28a, Date of Injury (Month) Day Year) 27. Menner of Death 28b. Time of after death.

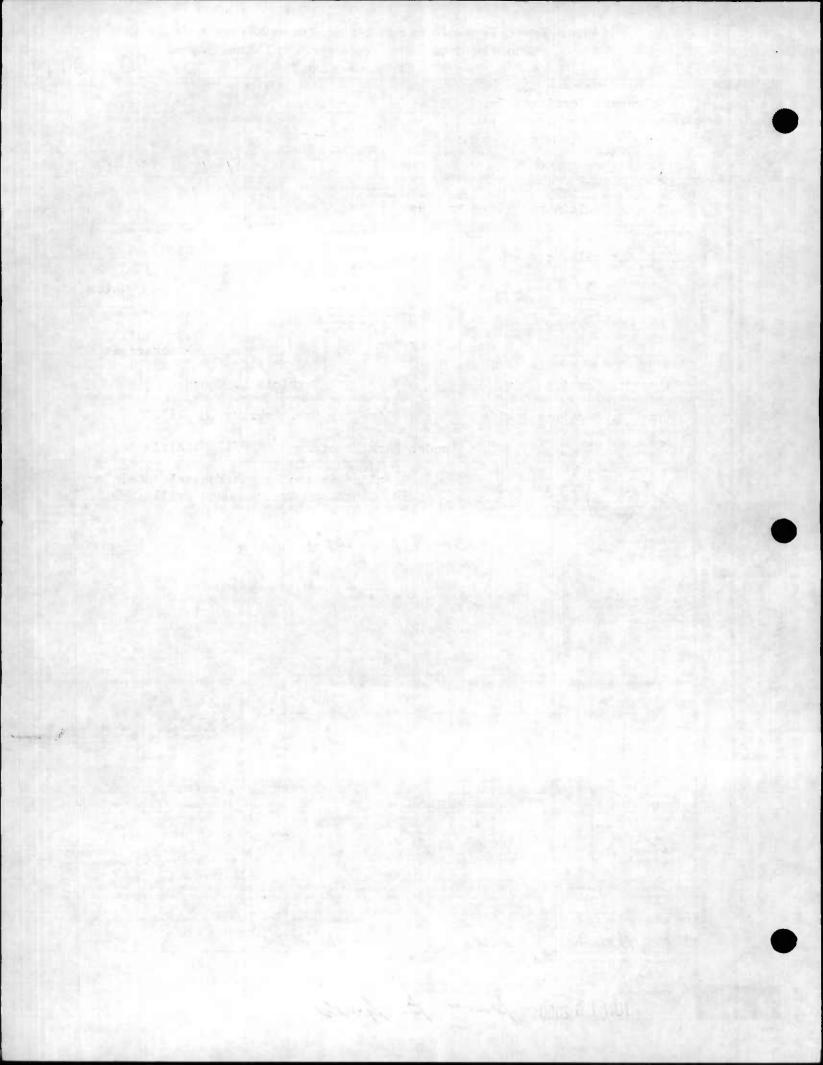
I Director: After the in by the funeral 28c. Injury at Work? 28d. Describe how Injury occurred or Attending 1 Netural 5 Pending investigation subject shot self 1 Yes 2 No 2 Aceldeni 3 Sulcide 0117 AA 6-14-00 Location (Street and Number or Rural Route Number City or Town, State) JG 5-Sulfun Spring 120 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Biltimore Co. street within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated. 29e. Certifier edicai completely (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certified O.C.M.E. June 14, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

**DHMH 16 Rev 6/95** 

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#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 12 2000 GRACE 9:02AM /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death **Examiner** Baltimore HOSPITAL 7. Age In yrs. last birthdey) Kasedalo If Under 24 Hrs. If Under 1 Year 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours Months 1 M 2 F 246-16-9817 Director Usual Residence of Decede 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 KNo HUMOR Funeral Director 284-1 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code or items 23a or 21236 12. Was Decedant Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Maritat Status 1 Ø Yes 2 ☐ No #Yès, Give Yaar or Dates: W W ☐ 1 ☐ Never Married 2 Married 1 Yes 2 No Specify. Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Com. Il Hygiene. Telephone Elementary/Secondary (0-12) College (1-4or 5+) Repail 12 poemit. Peges 1 and 2 should be file. Department of Health and Mentel Hy, important: if New 27 is marked other any Induty or other transfer 17. Father,'s Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Baltimore Md 21237 NIECO laylor 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) June 16 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Furural Service Licenses Part / Enter the disease, or complications that caused the dishock, or heart failure. List only one ceuse on each line. **Physician** Immediate Cause (Finel disaase or condition resulting in death) /Medical Examiner Due to (or as a consequenca of): Completed by Physician/Medical Examiner the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequenca of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? certificate hes 2 X No 1 ☐ Yes 2 ☐ No tal or Attending Physician: The state death. It Director: After this certificated in by the funeral director, p. Medical Certification: To Be 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) 1□ Yes 2 No Hospitel: 1 Inpatiant Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending invastigation 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide

The law requires that the death certificete be executed Box 68760. P.O. of Vital Records, Division

death with the Meryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

To the Hospital o within 24 hours at To the Funeral D State Registrar

filled in by

29c. Licanse number 29b. Signature and titte of cartifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

UNZ 12, 2000

cause of death (Item 23a) (Type, Print 30. Name and address

Square DR.

31. Date filed (Month)

4 Homicide

29e. Certifier (Check only one)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death h's Name (First, Middle, Last) 2. Date of Death Month Physician 7000 OR /Medical Name (If plot institution, give signet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner INSHOPIERS BAVIER TIMONE 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country)
 MARYLAND 7. Age (In yrs. last birthday) **Funeral** Days 1 🛛 📈 2 🗆 F Yrs. 70 Director SEPT 15 1929 220-24-7922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow. r than "natural", or frems 23s or 28s-f show the Medical Examiner must be notified at 1 Xes 2 □ No Director MARYLAND N/A BALTIMORE CITY 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 6225 YORK ROAD APT E406 21212 Funeral U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mentel Hygiene.
Important: If Item 27 is marked other than "natural", or her any injury or other traumatin. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th grade LABORER MARYLAND CUP COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 CHARLES N. GRIFFIN PEARL DOWDY 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Guye/Daughter 5010 Sipple Avenue, Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Peurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-16-00 BALTIMORE, MARYLAND ZION CEMETERY 22. Nama and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23a Fart1. Enter the disease, or compositions shock, or heart tailure. List only on Approximate Intervel Between Onset and Death cations that cause ne cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician /Medical mediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a co physician the burial Physician/Medical Cause (Disease or inju-that initiated events resulting in death) Last Dua to (or as a consequence of) USI Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. P.0. the i 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably SUnknown Records, b 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 20 No 1 □ Yes 28 No 1 Yes certificate of Vitai 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitel: Inpatient Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Natural 2 Accident or Attending 5 Pending Investigation after deeth.

Director: After din by the fur 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcida 28e. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral Di Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and addrass of person who gomp eted cause of death (Item-23a) (Type, Frint) BAVMON KOBA

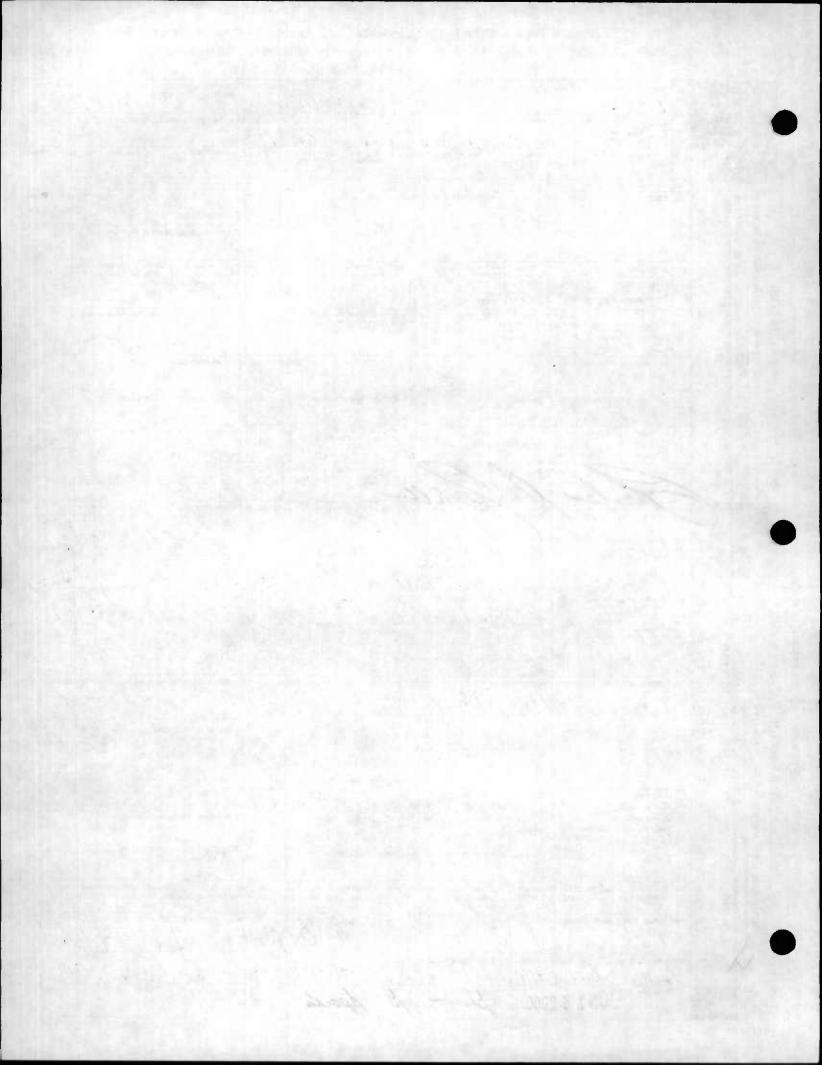
Registrar

State

31. Date filed (Month, Day

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32. Registrar's Signatura



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Daath 3. Tima of Death Month **Physician** LLOYD GAUSS JUNE 7, 2000 9:45 PM ' /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daeth 4c. County of Desth **Examiner** GENESIS ELDERCARE- HAMMONDS LANE Baltimore Baltimore If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Dey, Year) Aug 24, 1916 if Undar 24 Hrs. 7. Aga (In yrs. last birthday) Funeral Months Days 1X M 2□ F Director 212-05-3637 ΜD Usuel Rasidence of Decedant with the Maryland 10a. Stata 10c. City. Town or Location 10d. Insida City Limits Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MD Baltimore 1 Yas 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 613 Hammonds Lane permit. Pages 1 and 2 should be filed within 72 hours efter death vibebrinent of Health and Mental Hygiene. Important: if fem 27 is marked other than "natural", or flema 23 any injury or other tranmatic event, the Medical Examiner must any injury or other tranmatic event, the Medical Examiner must Funeral 21225 14. Race - Amarican Indian. 12. Was Decedant Evar in U,S. Armed Forcas? 1 X Yas 2 □ No If Yes, Giva Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2X No Spacify: Specify: þ white 3 Widowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Eiamentary/Secondary (0-12) Collega (1-4or 5+) truck driver meat company 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Emma Rossmark 2 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) Michael Gauss/son 202 Mt. De Sales Road Baltimore, MD 21228

20b. Place of Disposition (Nama of camatary, cramatory or other place)

Baltimore, MD 21228

20c. Location - City or Town, Steta 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 □ Donation & WQthar (Specify) in state 21. Signature of Furreral Service Licensee Ropald S. Wade 22. Nema and Addrass of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Band disaasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, about, or heart failure. List only one cause on each line. Approximeta Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Hypoxemia Examiner Due to (or es e consequence of): Examiner Presmonia ration Sequentially list conditions, if any, laading to immediata cause. Enter Undarlying Cause (Disaasa or injury that initiated avants resulting in daath) Lest Due to (or as e consequence of) and burial-trar The law requires that the death certificate be execu Records, P.O. Box 68760, Physician/Medical the Dua to (or as a consequence of) 98 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? been signed by the should be deteched VASCULAR DEMENTA 1 Yes 2 No 3 Probably 4 ☐ Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Congestive Heart Failure 1 Yas 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certifice Be 25. Was casa rafarred to medical 26. Placa of Death (Check only one) exeminar? Other: 4 Nursing Homa 5 Residence 6 Other (Spacify) P 1 Yas 200 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Panding invastigation 1 Neturai 2 Accidant 6 Could not be detarmined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 28f. Location (Straat and Numbar or Rurel Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and dua to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, and dua to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D53462 JUDE MUNESES, MD 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 7845 OA Kwood
31. Dete filed (Month, De), Year) Load Glen Burnie, MD

32. Ragistrar's Signatura

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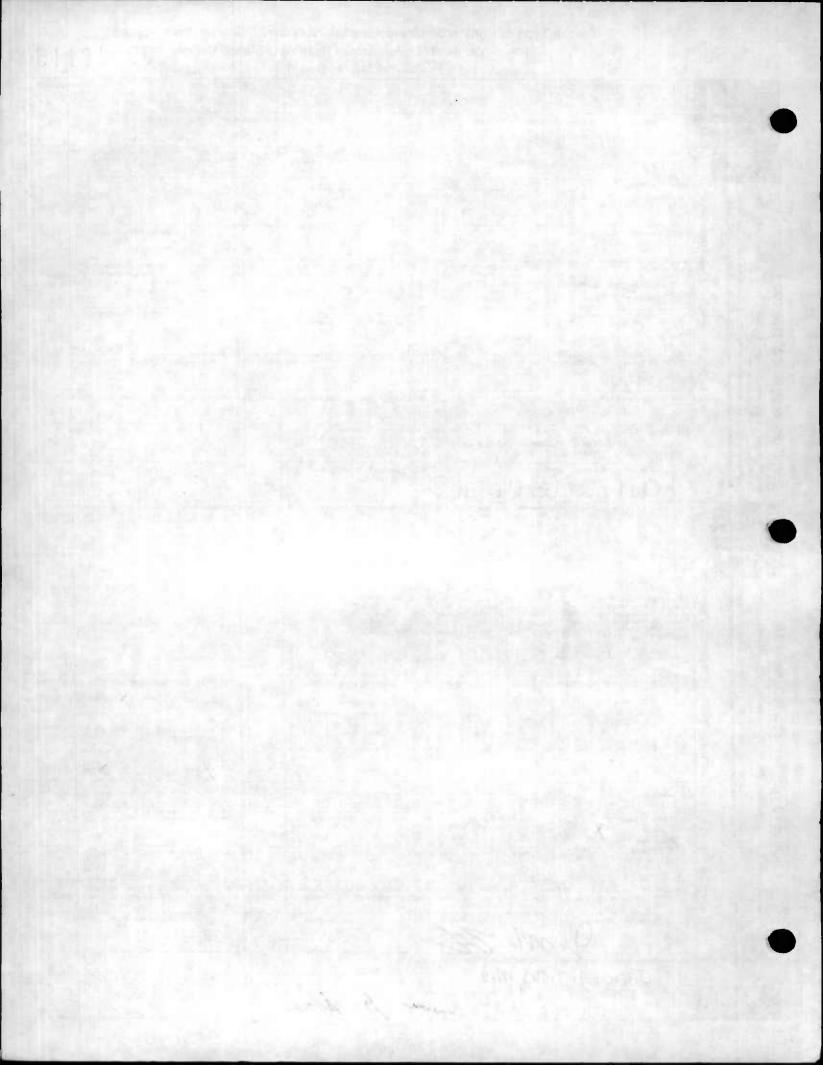
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tor	MD NA	Ва	ltimore	9				1₽	Yes 2□No
- Sire	10e. Street and Number		1	Of. Zip Code		1	0g. Citizen of V	Vhat Country?	
rai	2000 Kennedy	Avenue		212			USA		
by Funeral Director	11. Meritel Stetus  1 Never Merried MMerried  3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Decedent of H s, specify Cube Yes 2 No	ispanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- lo Rican, etc.)	14. Race Blec Specify	e - American Indie k, White, etc.	n,
2	15. Decedent's Ed	Year or Detes:	16a. Decedent	's Usual Occup	ation		16h Kind at Bu	Black usiness/Industry	
Completed	(Specify only highest gra	de completed)	(Give kind	of work done of NOT use retired	during most of wo	rking	TOO. TIME OF DE	ion room radion y	
mo	Elementery/Secondery (0-12) 11th Grade	College (1-4or 5+) NA	Truck	Drive	r		T & T	Recking	9
Be	17. Father's Neme (First, Middle, Last)		TO VICE Y			me (First, Middle,			
10	Roland	Hanibal			Louis			ter	22005
	19a. Informent's Neme/Rejetionship ( Sadie Pear		19b. Meiling A 529 N	ddress (Street	and Number or Rivod Av	enue Ba	r, City or Town, ltimor	Stete, Zip Code)	yland
	20a. Method of Disposition 1X Buriel 2 ☐ Cremetion 3 ☐		Piece of Dispositio	n (Name of bry or other place	e)	Dete	20c. Location -	City or Town, Stel	10
	4 Donetion 5 Other (Specific		shell M	lem. G	ardens	06-19-2	000 Du	indalk,	MD
	21. Signeture of Funerel Service Licer	SOO RICIDA		C. Mar		altimor		yland :	21202
	23a. Pert1. Enter the diseese, or com- shock, or heert feiture. List only	olications thet caused the deal one cause on each line. HYI	th. Do not enter the PERTHERMI	A COMP	g, such es cardia LICATING	or respiretory err	rest, NSIVE		imete I Between and Deeth
ian cal	Immediete Cause (Final	ATHEROSCLE	ROTIC CAP	RDIOVAS	CULAR DI	SEASE ANI	CHRON:		
ner	disease or condition resulting in death)	• OBSTRUCT			ISEASE		القيروالا	1	
ě		Due 10 (-	or es a consequen	ce or):					
Examiner	Sequentially list conditions,	b. — Due to (	or es e consequen	ce of):					
EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
edicai	thet initiated events resulting in deeth) Last	Due to (c	or es e consequen	ce of):					
Me	THE RESERVE	d							
cian						1 2-1 2-1			
Physician/M	Pert II. Other significant conditions of	ontributing to death but not res	sulting in the under	fying cause giv	en in Part I.			Probably	
by						101	'ss 2□ No		4 Unknown
Completed						24e. Wes e perfor	en eutopsy med?	24b. Were auto aveilabia p completion	rior to
npie					-			of death?	. Or Cause
Con						1)X(Y	es 2 No	1)X Yes	2□ No
Be	25. Wes case referred to medicat examiner?	Mosnito)		104		ath (Check only o	ne)		
. To	1 No 2 No 2 No 27 Merces of Deeth			DOA Oth	4 Li Nursing i	dome 5 Resid		er <i>(Specify)</i> red EXPOSUI	DE TO
Certification:	27. Menner of Death 1 □ Neturel 5 ending	28a. Dete of Injury (Month, Day Year)	28b. Time of injury	A 28c. Injur Wor	yat k? Yes 2∭No				-
ficat	2 Accident Investigation 3 Suicide 6 Could not be	0 12 00 (10)	<i>y</i>			HIGH ENV	I RONMEN	NTAL TEMI	PERATURI Number_
ert	4 ☐ Homicide determined	building, etc. (Speci	ME	3, 5,000		City or Tow BALTIMON			AVE.
	29a. Certifier 1☐ Certifying Ph	valcian: To the best of my kno	owledge, deeth oc	curred et the tin	na, date and plec	e, end due to the o	euse(s) and me	enner es stated.	
edicai	(Check only 2 Medical Examone)	iner: On the basis of exemine end manner steted.	etion and/or investi	igetion, in my o	pinion, deeth occ	urred at the time, o	tate end place,	and due to the cer	use(s)
ž	29b. Signeture and title of couling	1		29c. Licens		2	29d. Date signed (Month, Dey, Year)		
		00/1.		0.0	C.M.E.		June 1	2, 2000	
	4//	1111/1/							
	30. Neme and address of pegion who				X II-lean	475			
	30. Name and address of pages who who start the start of	completed cause of deeth (item TVS, M.D.			Street,	Baltimor	e, Mary	land 2120	01

DHMH 16 Rev 6/95

**ORIGINAL** 



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Many epartment of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** June 9, 2000 10:00 P.M. Norman L. Henninger /Medical 4b. Cify, Town, or Location of Death 4a Facility Name (ff not institution, give street and number) 4c. County of Death Examiner Baltimore Towson Manor Care Towson Nursing Home If Under 1 Yeer 8. Date of Birth (Month, Day, Year) 1-13-1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min 1 M 2□ F Months Days Hours Maryland Yrs. 71 Director 214-22-6387 Usuel Residence of Decedent the Maryland 10c. City. Town or Location 10d, Inside City Limits 10a State 10b. County 28a-f ahon traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☒ No Director Maryland Baltimore Timonium 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? WITH 6 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mertal Hygiere. Important: if item 27 Is marked other than "natural! ..." any injury or other traumatic event. 21093 S. A. 751 Leister Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Types 2 To No If Yes, Give Year or Dates: Kore Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Korean Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) Md. Toll Facilities Police 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Henninger Sadie Jones Elmer 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Retationship (Type, Print) 751 Leister Drive, Timonium, Maryland 21093 Mrs Charmaine Liddicoat (DTR) 20b. Plece of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Hilltop Services Corp. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-12-00 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. Wallace S-Bloody J. 1050 York Road, Towson, Md.

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1050 York Road, Towson, Md. 21204 Approximate tritervel Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical ZRIO SCLEROTIETEART DISEASE **Examiner** Physician/Medical Examine ONIC The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events P.O. Box 68760. Due to (or es a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 24e. Wes an eutopsy performed? Were autopsy findings available prior to completion of cause of death? this certificate has 1 Yes 2 XNO 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 □ Natural 2 □ Accident 5 Pending investigation Injury 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier To Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and plece, and due to the cause(s) and menner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number end title of certifier

**DHMH 16 Rev 6/95** 

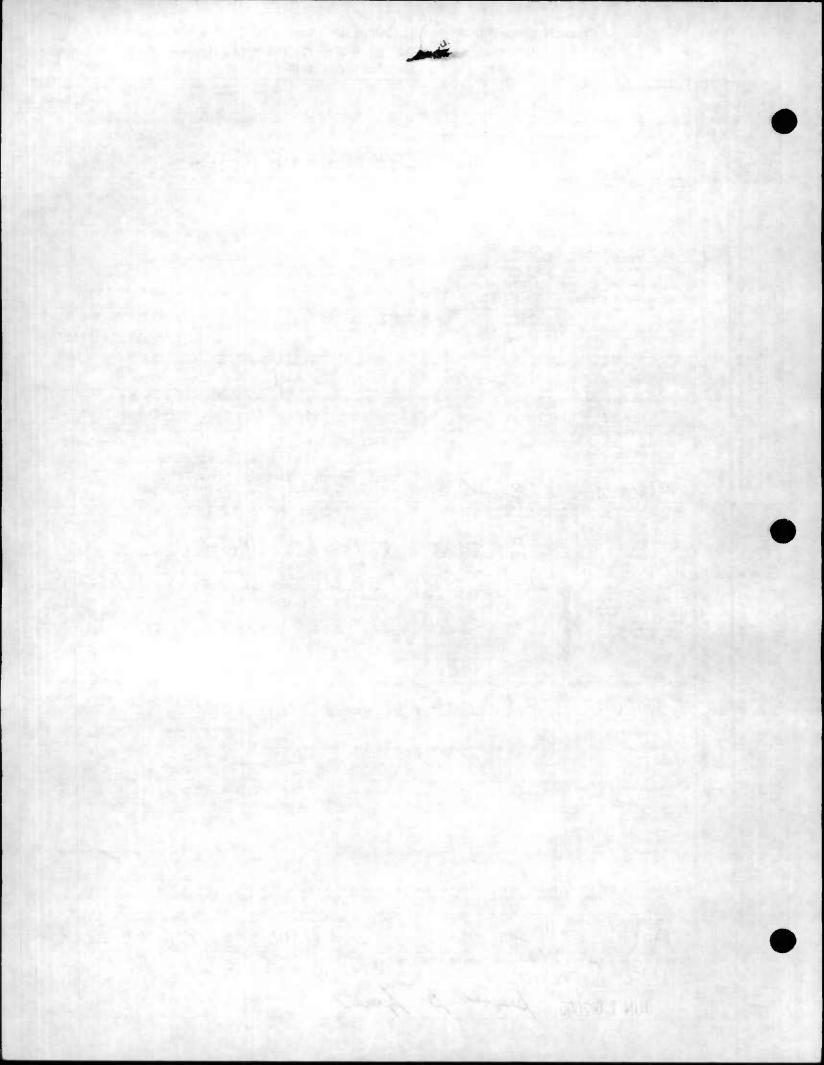
Registrar

31. Date filed (Month, Day, Year) JUN 1 6 2000

IRASHAKAR MO /32. Registrar's Signature

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

SOO ARMORY PLACE BAL, MDZIZON



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** JUNE 10 2000 1:40 pm HERMAN P. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MANOR CARE ROSSVILLE ROSEDALE BALTIMORE If Undar 1 Yaar | If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F Yrs. Director 218 03 7495 Jan 15, 1920 MARYLAND Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23s or 28s-f show Examiner must be published at 1 ☐ Yas 2 🛣 No Director Raspeburg **Baltimore** 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? 5619 Daybreak Terrace 21206 Funeral USA Raca - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Ricen, atc.) 11. Marital Status pemit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiena. Important: if fem 27 is marked other than "natural", or his important: if fem 27 is marked other than "natural", or his injury or other traumatic avent, the Medical Examples page. 1 K Yes 2 □ No If Yas, Give Yaar or Dates: 1 Never Married 2 Married 1 ☐ Yas 2 KNo Specify: à Specify: 3 Widowed 4 □ Divorced WWII White Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elemantary/Secondery (0-12) Collega (1-4or 5+) Brewery Driver 6 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Louise Rose 10 William Hart 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 1 Troon Court, Baltimore, MD Wilson Hart/Son 21236 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Data 1 ■ Burial 2 Cramation 3 Removel from Stete 4 ☐ Donation 5 ☐ Othar (Specify) Sacred Heart of Jesus 6-14-00 Baltimore, MD 21. Signetura of Funaral Sarvice Liqui 22. Nama and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue, Baltimore, MD 21237 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Daath **Physician** Stage chronic obstructive /Medical Immediata Causa (Final disaasa or condition rasulting in deeth) **Examiner** Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, laading to immediata ceuse. Enter Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Physician/Medical Dua to (or as e consequenca of) signed by the a 23b. Did tobecco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. No 3 Probably 4 Unknown þ The law requires 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? Completed complation of causa of daath? page 2 1 Yas No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarred to medicel examinar? Be 26. Placa of Death (Chack only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Homa 5 Rasidance 8 Othar (Spacify) 1 Yes 2 No To this funeral 27. Mannar of Death 28d. Describe how injury occurred Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? After Netural Attending 5 Pending death. 1 ☐ Yas 2 ☐ No invastigation n 24 hours after death le Funeral Director: / pletaly filled in by the 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datermined 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide ò Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, dete and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifiar To the Hosp within 24 hor To the Fune completaly fi (Check only one)

State **DHMH 16 Rev 6/95** 

altimore, Maryland 21215-0020

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31. Dete filed (Month, Day, Year) JUN 1 6 2000

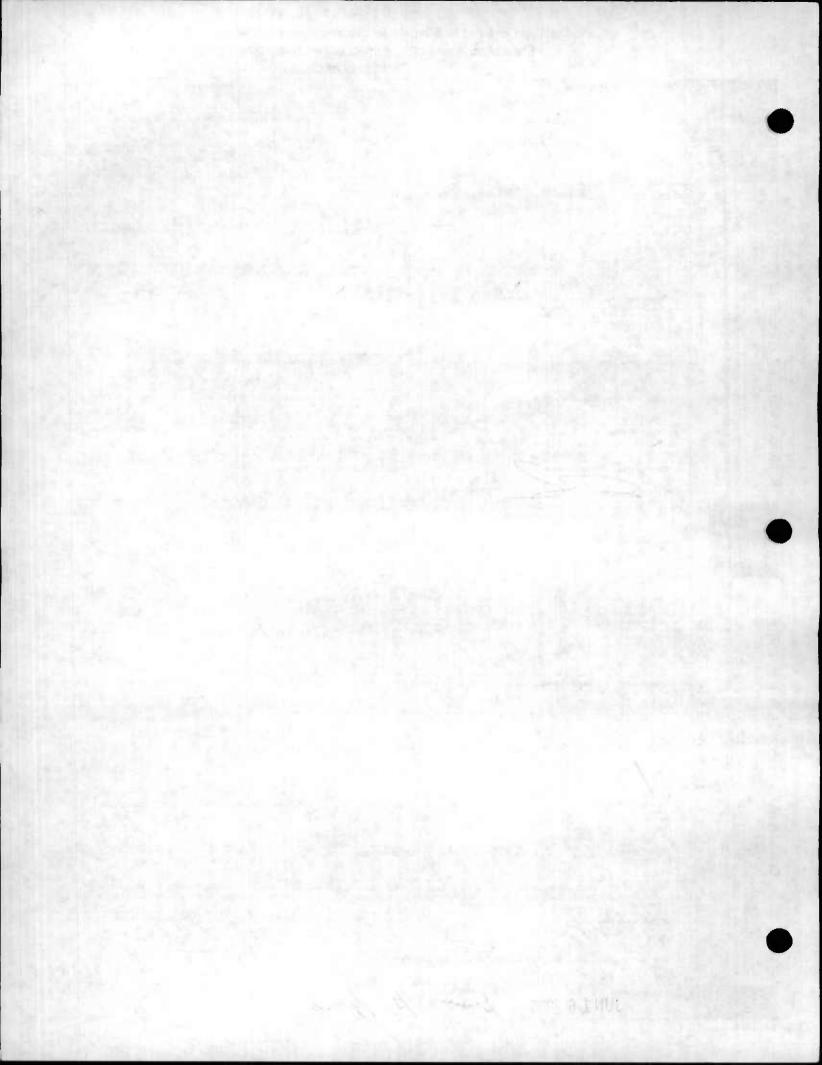
uan us 30. Name end address of person who completed ceuse of deeth (Item 23a) (Type-Print)

29b. Signatura and title of continue

5601-Loch 32. Registrar's Signature

29d. Data signed (Month, Day, Year)

Baltimore MO 21239



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Marjorie McLane Hyde June 13 2000 11:35 pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 208 Norwood Road Annapolis Anne Arundel If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 XF Yrs 307-22-3899 74 Director Dec. 14,1925 Indiana Usual Residence of Decedent death with the Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits r than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at 1 X Yas 2 □ No Director Anne Arundel Annapolis 10g. Citizen of What Country? 10e Street and Number 10f Zio Code 208 Norwood Road 21401 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Bleck, White, etc. 12. Was Decedent Evar in U,S. Armed Forcas? 11. Marital Stetus filed within 72 hours after 1 ☐ Yas 2 🖾 No If Yas, Giva Year or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify. à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Peges 1 end 2 should be nent of Health end Mental 27 la marked o Frank McLane 2 Alice Overmeyer 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straaf and Number or Rural Routa Number, City or Town, Stele, Zip Code) permit. Peges 1 end 2 s Department of Heelth er Important: if item 27 la any Injury or other trau pince. Francis Hyde (Husband) 208 Norwood Road, Annapolis, MD 21401 20b. Place of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stata Date cematary, cramatory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD of Funeral St 22. Nama and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Entar the disease, or complications that baused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata interval Between Onset and Death Physician obstructive pulmonay disorder - unknow /Medical Immediata Ceusa (Final disaase or condition resulting in deeth) Examiner Dua to (or as a consequence of) Examine physician and the burial-trensit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Disease or injury that initiated eventa rasulting in death) Last Dua to (or as a consequenca of): Box 68760. Physician/Medical The law requires that the death certificate be Dua to (or as a consequenca of) SB esn P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown been signed the should be det Records, þ 24b. Ware autopsy findings available prior to complation of cause of death? 24a. Was an eutopsy performed? Completed has page 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred Affer Attending 1 Natural 2 Accident 5 Pending invastigation death. 1 Yas 2 No Director: / 6 Could not be 28f. Location (Straat and Number or Rurel Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, atreet, factory, offica building, etc. (Specify) after 4 Homicide 6 To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Certifying Physician: To tha best of my knowledge, death occurred et the time, data and placa, and due to the causa(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signeture and little of certifie 29d. Data signad (Month, Day, Year) 29c. Licensa numbar 8101 2000

State Registrar **DHMH 16 Rev 6/95** 

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polis MD 2140 / Donna

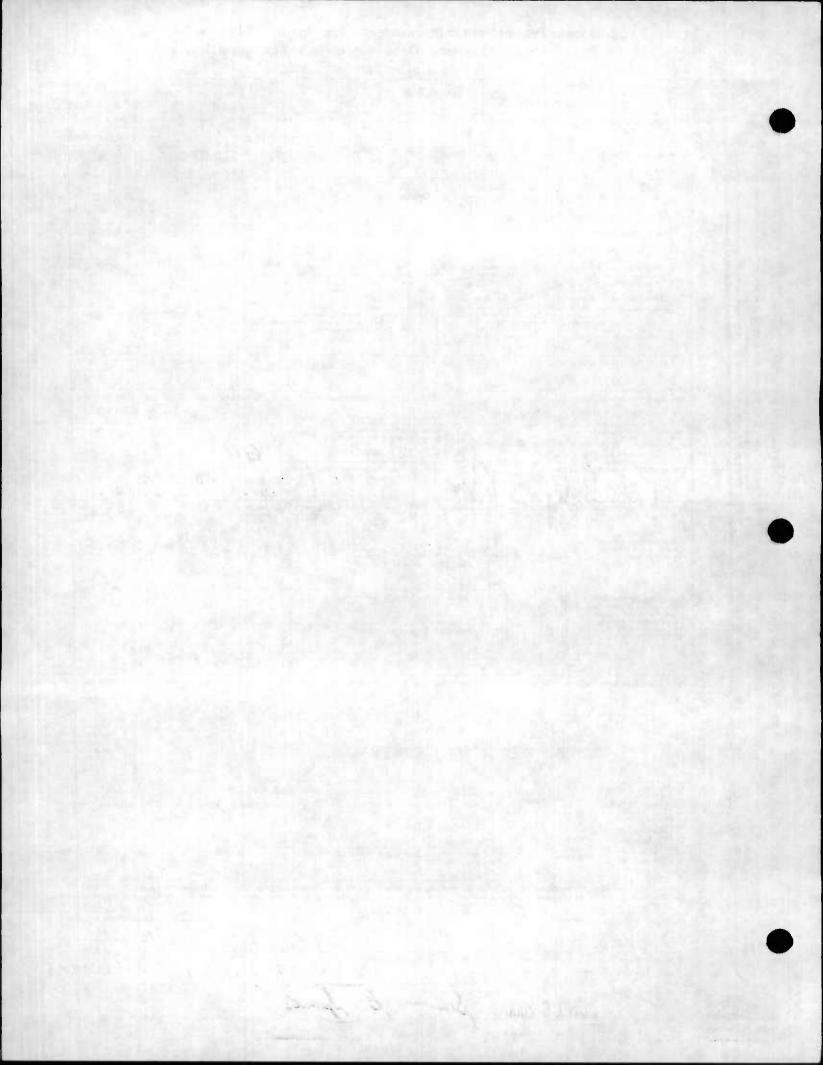
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2000

32. Registrar's Signatura

31. Data filed (Month, Day, Year)



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 00 PM Month Day 06 - 08 - 00 **Physician** ELLIS M. HOWARD /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PIKESVILLE 4784 BONNIE BRAE ROAD BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 1 - 05 - 4 5. Social Security Number 9. Birthplaca (State or Foreign Country)
ALABAMA 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F 58 216-42-8905 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD BALTIMORE PIKESVILLE 204-4 10e Street and Number 10g. Citizen of What Country? 10f Zin Code "natural", or items 23a or 4784 BONNIE BRAE ROAD 21208 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, Whita, etc. 11. Marital Status filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Giva 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: BLACK by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) NIA EQUIPMENT SPECIALIST US. ARMY 12-11 GRADE cs, Marylans, Depart and 2 should be file. Department of Health and Mental Mental More any Injury or other 27 is mediany figury or other. 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Name (First, Middle, Last) Be CLANFORD HOWARD GANDY LUELLA 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PKESVILLE, MO . 21\_ 20c. Location - City or Town, State M. HOWARD 4184 BONNIE BARE WIFE RO. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Ramoval from Stata 6-13-00 OWINGS MILLS, MO GARRISON FOREST 4 ☐ Donation 5 ☐ Othar (Specity) 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter(the disease, or complications that caused the death. Do not anfar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lasf Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part It. Other eignificant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? Chronic Renal 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medicel examiner? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation s after death.

I Director: Aft od in by the fur 1 Tyes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) 4 Homicide To the Hospital owithin 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier edicai 29b. Signatura and the of certifier 29c. License number 29d. Data signed (Month, Day, Year) 00050559 (dellen aranes 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 720 Retard Ave Baltmore MD 21205 ROSS 1025 Laurence Gardner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 6 2000 Registrar

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**DHMH 16 Rev 6/95** 

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	4 December 141 Alexander			OGI	rtificate of	Dealli	1 -		g. No.		0.71
Physician	1. Decedent's Name (First, Mi	office of the second					2.	Date of Death Month	Day	Year	3. Time of Deat
/Medical	HERMAN R.  4a Facility Name (If not institu	JONES, SR.	m from l			4b. City, Tov	un or Locat	May 31	4c. County	of Dooth	5:38 PM
Examiner	Greater Balt			-02		_		ion or Doutin			
mount	5. Social Security Number	6. Sex	7. Aga (In yrs.		If Under 1 Year	Tows o		Date of Birth (Month, Day,		imore	lace (State or For
uneral rector	219-12-7968	1∭ M 2□ F	74	Yrs.	Months Days	Hours	Min.	(Month, Day,	1925	Coun	MD
	Usual Residence of Decedent										
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 5:35 AM CLEVE JOHNSON JUNE 14,2000 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death MANOR CARE RUXTON PUXTON BALTIMORE If Under 24 Hrs. If Under 1 Yeer 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Deys Hours 104M 20 F Yrs. 80 266-05-8384 GEORGIA Usuet Residence of Decede 10a, Stete 10b. County 10c. City, Town or Location 10d. toside City Limits 1 Yes 2 No MD TOWSON BALTIMORE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Race - American Indien, Bleck, White, etc. 21204 STREET 7001 CHARLES 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 □ Divorced BLACK 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondary (0-12) Cotlege (1-4or 5+) P.J. FLANIGAN CONSTRUCTION 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) MOSUHIOL (UNICHOWN) (UNKNOWN) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Nems/Reletionship (Type, Print) APT. I BALTIMORE MD. 21239 Date 20c. Location - City or Town, State 6537 RD. YVETTE FULLER, DANGHTER FALKIRK 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition TIME 15, 1 ☐ Burlat 2 ☐ Cremetion 3 ☐ Removel trom State 4 ☐ Donetion 5 ☐ Other (Specify) BELAIR - P.A. FOREST HILL, MD. 2000 22. Neme end Address of Fecility EVANS FUNERAL CHAPEL 21. Signature of Funeral Service Licensee 8800 HARFORD RD. PARKVILLE, MO. 21234 ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Intervel Between Onset and Deeth Immediate Ceuse (Finel ALZHEIME disease or condition resulting in deeth) Years Due to (or es e consequence of): Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the causs of death? 1 ☐ Ysa 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ATHER OSCLE ROSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical 26. Place of Deeth (Check only one)

Examiner Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Physician/Medical

**Physician** 

/Medical

Director

Funeral

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**Funeral** 

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Baltimore, Maryland 21215-0020

filed within 72 Hygiene.

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Physician /Medical

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Certification: To

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The law requires that the death certificate be executed

Box 68760

Records, P.O.

Division of Vital

Physician:

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To the Hospital o within 24 hours of To the Funeral Di completely filled in

the Medical Examiner must be

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

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6-14-00

1□ Yes 2☑ No 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and titte of certifier

alach 30. Name and anchess of person who completed cause of death (Item 23a) (Type, Print)

7600 MD. GHILADI M.D. OSLER DR. TONSON

State Registrar

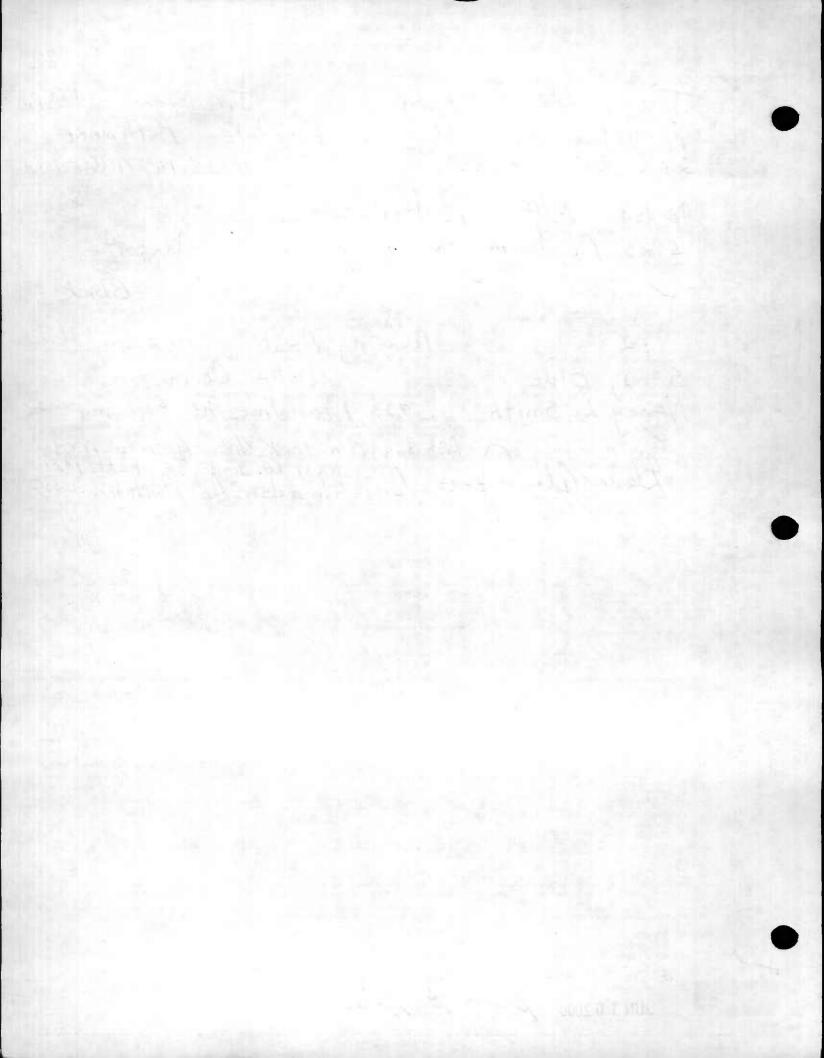
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death **Physician** 2000 16 une /Medical 4c. Qunty of Deeth Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner 5. Sociel Security Number 8. Defe of Birth Month, Dev 9. Birthplace (State or Foreign AROLINA **Funeral** 10M 20F Days Hours 220-36-5954 Usual Residence of Decedent Yrs. Director 10a. Stete 10b. County 10c, Ojty, Town or Location 10d. Inside Offy Limits 1 Yas 2 No MARYland Director mor 10e. Street and Number 10g, Citizen of Whet Country? 8 14. Race - Amarican Indian, 723 101 me 21206 Nems 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Merried Saltimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed by Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) SST RSING permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If Nens 27 is marked offer any injury or other trausmetic event 17. Fathar's Nama (First, Middle, Last) . Mother's Neme (First, Middle, Maiden Sumeme) Be Andy ovington et and Number or Rural Routa Number, City of 19a. Informent's Name/Relationship (Type, Print) m, Steta, Zip Coda) Ancy 72 SALTO 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 □ Cremetion 3 ☐Removel from Stete abu tus 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service 391to Md SUN Approximate Intervel Batween Onset and Deeth 23a. Part1. Enter the disease, or complications that chused the death. Do not shock, or heart feilure. List only one cause on a chiline. **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury P.O. Box 68760 that initiated events resulting in death) Last Dua to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Records. Be Completed by 24b. Wera eutopsy findings available prior to 24a. Wes an eutopsy performed? completion of causa of death? 1 Yes 2 No N Yes 2 □ No certificate Division of Vital director, 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: \( \sum \subseteq \text{Nursing Home} \quad 5 \subseteq \text{Residence} \quad 6 \subseteq \text{Other} \( (Specity) \) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Neturel
2 Accident 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At 1 Yes 2 No 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicida Medical 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. completely (Check only one) 29b. Signatura and fitle of certifier 29c, License number 29d. Date signed (Month, Day, Year) 6-16-00 Naymundo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northern 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rav 6/95

Registrar

JUN 1 6 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month 3. Time of Death Yaar **Physician JENKINS** Mary Catherine 13, 2000 4c. County of Death 8:50PM 2000 /Medical JUNE 4a Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Days Hours Min. (Month, Day, Year)
May 11, 19 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign
Country) **Funeral** 10 M 20 F Yrs. 214-40-0067 Maryland Director Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits terms 23s or 28s-f show 1 ☐ Yas 2 ☑ No Director MD Baltimore Baltimore must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21209 U.S.A. 3 Railroad Avenue Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas ※ No If Yas, Giva Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, etc. 1 ☐ Never Merried 2 ☐ Married Maryland 21215-0020 1 Yes 2 No Specity: Specify: White ğ 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) be filed within 72 Elementary/Secondary (0-12) Collega (1-4or 5+) Gift Wrapper Department Store 18. Mothar's Nema (First, Middla, Maidan Sumame) 17. Fathar's Name (First, Middle, Last) 88 Mental is marked Julia Anna Smith Benjamin Oliver Brookhart, Sr. Pages 1 and 2 should 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 5 Duntore Pl. Apt. 2B, Baltimore, MD 21236 Amy McCusker- Grandaughter Baltimore, 20b. Plece of Disposition (Nema of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 6/17/00 Baltimore, MD 4 □ Donation 5 ☑ Other (Specify) Entombment Druid Ridge 21. Signeture of Funeral Service Licensee William G. Dau 22. Name end Address of Fecility Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical immediata Causa (Final Thorespirator diseasa or condition rasulting in death) **Examiner** Dua to (or as a consequence of): Examiner Multiple Organ The lew requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Duelto (or as a consequenca of): and Box 68760, physician 10300815 Physician/Medicai the Dua to (or as a consequence of): for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown signed t Records. by 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of causa of death? page 2 hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No of Vital 25. Was casa rafarred to medical axaminar? Be 26. Plece of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) Medical Certification: To 1 Yas 2 No s after dea. this 27. Mannar of Death 28a. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Division or Attending 128Natural 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Straef and Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) filled in by 4 Homlcide To the Hospital o within 24 hours af To the Funeral D 1K Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end manner stated. 29a. Cartifier completely (Check only 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signature and title,etc.

Registrar **DHMH 16 Rev 6/95** 

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S. F. Johnson W. TSU.

S. F. Johnson W. TSU.

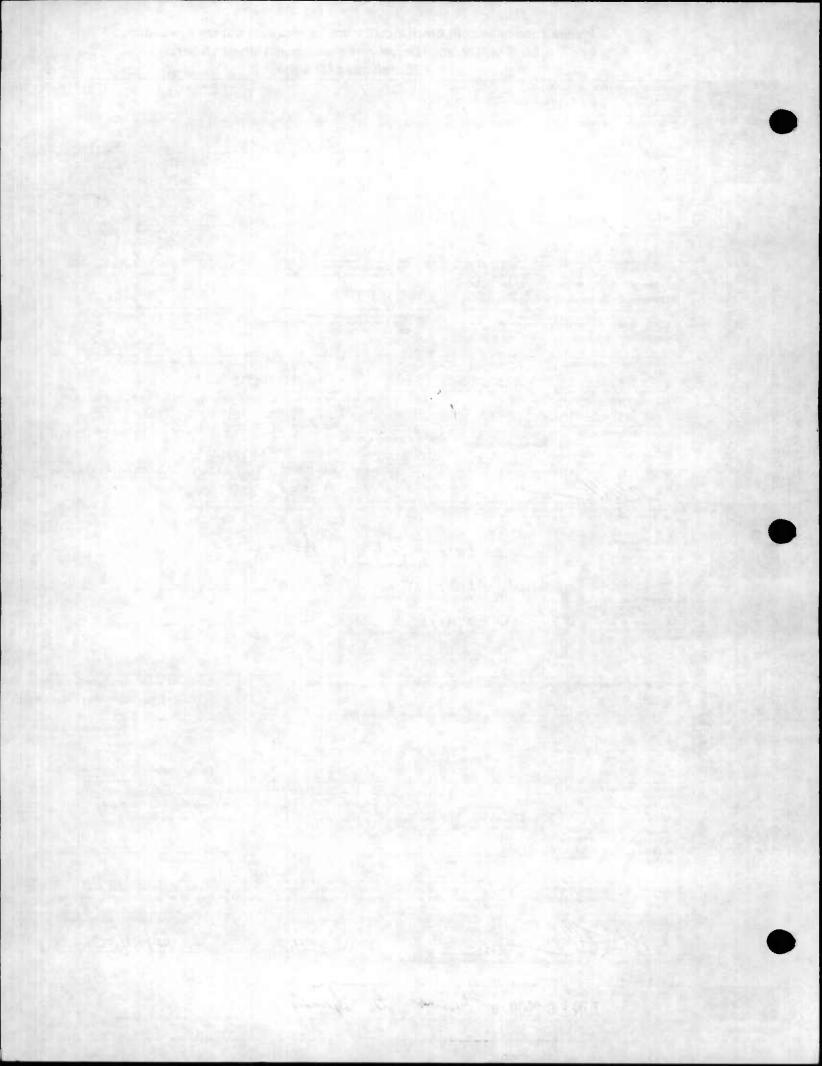
32. Registrar, Signatura

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

31. Data filed (Month, Day, Year)

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Do Suite 508, Towson,

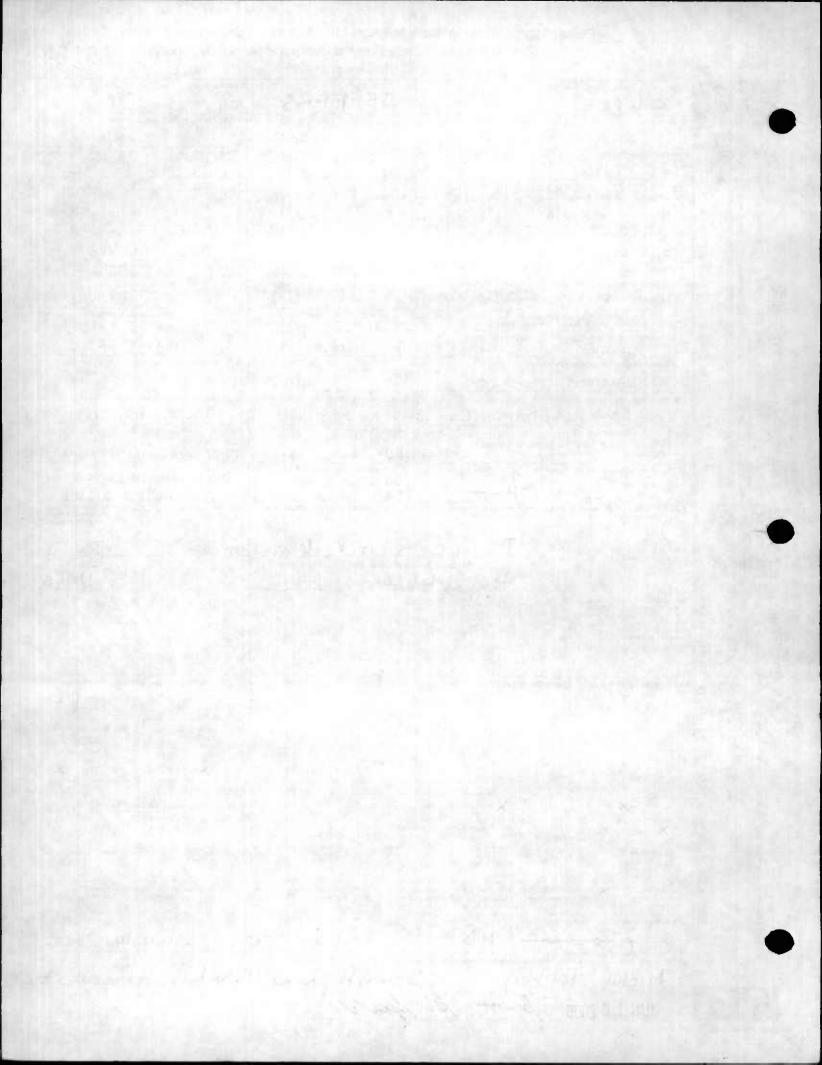


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth Day **Physician** CLYCE JEFFERS JUNE 2000 17:26 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE NA 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 65 216.30.7476 Director Usual Residence of Decedant 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Was 2 No MD NIA Directo BALTIMORE 288-4 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 a 23a must 2828 E. FEDERAL STREET USA 21213 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, Whita, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 □ Yes 2 ☑ No Specify: 9 þ If Yes, Give Year or Dates: Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 TH GRADE College (1-4or 5+) ARMCO STEEL STEEL WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit ment of Health and Mental H tant: If Nem 27 is marked off jury or other traumetic even Be CORNWALLACE JEFFERS MARY ABBOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TEREE MOORE 1544 KENNEWICK RD., BALTO. MD. 21218 DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burlal 2 □ Cremation 3 □ Removal from State KING MEMORIAL PARK 4 ☐ Donafion 5 ☐ Other (Specify) 16.17.00 RANDAUSTOWN, MD 21. Signature of Funarai Sarvice Licensaa 22. Name and Addrass of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Ente (the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line. PIKE, BAUD, MD. 21229 Approximate Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Fine) disease or condition resulting in death) tracerebro Days Examiner Due to (or as a consequance of) Physician/Medical Examiner pertension hysician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Box 68760. that initiated events resulting in death) Last Dua to (or as a consequence of): USB as t P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco uas contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy certificate has 9089 1 XYes 2 □ No 1 Yas 2 No of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Medical Certification: To After this 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending invastigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, facfory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. pletely 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signatura and fitte of certifier MD -000 June 14/2000 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital, Baltinae, Is Michel Der 31. Date filed (Month, Day, Year) Registrar's Signatura State JUN 1 6 2000 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Month **Physician** D6(JUCE) 13 2 0 8:00 am Robert Crawley Jones, Jr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3004 Dunmurray Road Dundalk r | If Under 24 Hrs. | Baltimore 8. Dete of Birth (Month, Dev. Year) Sept. 18, 1909 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) Funeral Hours Months Deys 15 M 2□ F 90 Sept. 215-03-9665 **Usual Residence of Decedent** 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Baltimore Dundalk 1 Yas 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3004 Dunmuarry Road 21222 USA permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mentel Hygiene. Important: If item 27 is marked other the any injury or other trainments. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Stetus 1 Yes 2 No 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Western Elementery/Secondary (0-12) College (1-4or 5+) 12 Draftsman Electric 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Robert Crawley Jones, Sr. Marie E. DEan 0 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Linda Jones- daughter 3004 Dunmurray Road, Dundalk MD 21222 20b. Plece of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, State Meadowridge Mem Park Burial 2 Cremation 3 Removel from Stete 6/16/00 Elkridge, MD Donetion 5 Other (Specify) 22. Name end Address of Facility Bradley Ashton Matthews Funeral Home, Inc. 21. Signature of Funeral Service Licenses 2134 Willow Spring ROad, Dundalk MD 21222 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediete Cause (Finet diseese or condition resulting in deeth) CONGESTIVE HEART FAILURE Examiner ATHEROSCLEROTIC CORONARY VASCULAR DISEASE >15 YEARS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or as a consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 ☐ Yes 2 DaNo 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ InpatienI 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 ☐ Yes 2 ☐ No 28b. Time of 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 Yes 2 No

Box 68760 P.O. Records, of Vital

The law requires that the death certificate be executed

Director

show

d other than "natural", or flame 23a or 28a-f show evant, the Medical Examiner must be notified at

Physician

/Medical

Examiner

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Physician:

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death with the Maryland

Division To the Hospital o within 24 hours af To the Funeral Di completely filled is

Registrar

**DHMH 16 Rev 6/95** 

DAVID 31. Date filed (Month, Day, Year) State JUN 1 6 2000

2 Accident

3 ☐ Suicide

29e. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZAJANO

9101 FRANKLIN SQUARE DR. BALTO, MO 21237 32. Refistrer's Signature

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

18 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the ceuse(s) and menner es steted.

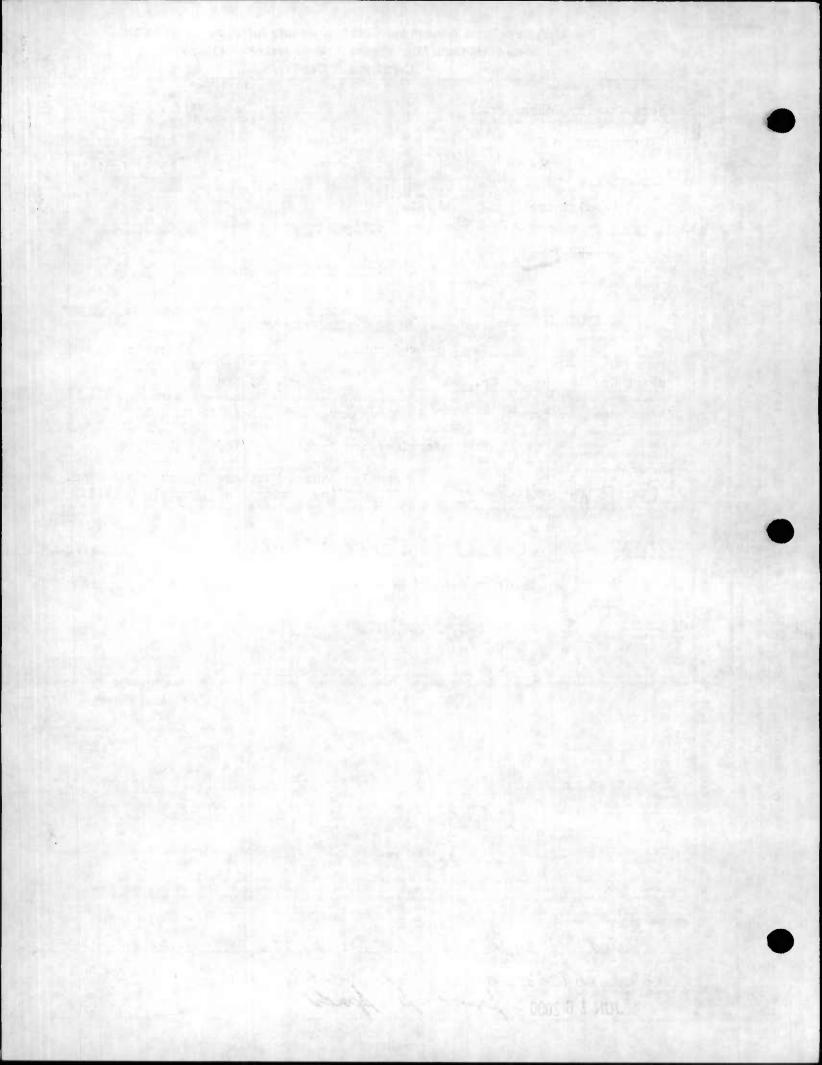
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end plece, and due to the ceuse(s) and manner steted.

29c. License number

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Dey, Year)

JUNE 15 2000



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day KNOX UCILLE WILMA JUNE 14 2000 3:40 AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death SPITAL 7. Age (In yrs. last birthday) AGNES 8. Data of Birth (Month, Day, Year) SALTIMORE If Under 24 Hrs. 8, Data of I 5. Sociel Security Number If Undar 1 Yaar 6. Sex Birthplace (State or Foreign Country) Months Days Min. Hours 1 M 25 F 247-07-7365 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ZYes 2 □ No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA. 14. Race - American Indian, Black, Whita, atc. NORTH EUTAW 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yas 2 No f Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 2K No Specify. 3 Widowed 4 □ Divorced BLACK Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING CO WORKER 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) MACK FRONEBERGER ILLIE 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) HAWKSBUR (NEICE) RD PIKESVILLE, MD. 21208 WILMA G, MARSHALL 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stata ZION CEMETERY 4 Donetion 5 Other (Specify) 46-17-00 LANSDOWNE, MARYLAND 22. Nama and Address of Facility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME 21. Signature Funeral Service Licer JOSEPH H. BROWN -2140 N. FULTON AVE. BALTO, MD, 2121 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory afrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Ceuse (Final disease or condition resulting in death) myocardial unknown Due to (or as a consequence of) cardiovasilar atheroscleronz UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. Stata

**Funèral** 

Director

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A Hygiene.

Department of Health end Mentel In-Important: If them 27 is marked oth-any Injury or other traumatic avant DRGs.

traumatic awant, the Medical Examiner must be notified at

Peges 1 and 2 should be filed within 72 hours efter death with

21215-0020

Maryland

Baltimore,

Funeral Director

Be Completed by

Physician/Medical Examiner þ Medicai Certification: To Be Completed

The law requires that the death certificate be executed and After this certificate hes eral Director: After this certific filled in by the funeral director, To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After

Records,

SOOK, LUCIL Registrar

completely 29b. Signature and title of certifier State

25. Wes case referred to medicat examiner? 1 Yes 2 No 27. Manner of Death 1 Neturat 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide 29a. Certifier

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year)

28b. Time of Injury

28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify)

28c. Injury at Work?

29c. License number

D47353

1 Yes 2 No

26. Place of Death (Check only one)

281. Location (Street and Numbar or Rural Routa Number, City or Town, State)

Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Baltomore, Maryland

28d. Describe how injury occurred

June 14, 2000

30. Name and address of person who completed causa ot death (Item 23a) (Type, Print) 900 Caton Avenue

St. Agnes Hospital Jon Falck MD

31. Data filed (Month, Day, Year) JUN 1 6 2000 32. Registrar's Signatura

**DHMH 16 Rev 6/95** 

### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Margaret Anna une /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST ROCKVILLE If Under 24 Hrs. 8. Da HOSPITAL MONTGOMERY If Under 1 Year 8. Date of Birth (Month, Day, Year) July 30 1906 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Months **Funeral** Deys Hours 1 M 20€F -54-7956 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department if them 27 is marked other than "natural", or hems 23a or 28a-f show eny injury or other traumatic svent. In a second or the state of the stat 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: Whis 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nome 17. Father's Name (First, Middle, Last) 18. Mother's Name (Firşt, Middle, Maiden Surname) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ob. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State June 20 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furural San 22. Name and Address of Facility Md 21234 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final neumonia two days disease or condition resulting in deeth) Examiner Examiner signed by the attending physician and doe detached for use as the burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that inhibated events resulting in death) Lest Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evalteble prior to Completed 24a. Was an autopsy performed? peen s completion of cause of death? has certificata 1 Yes 2 BNO 1 ☐ Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death. To the Funersf Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai

State Registrar

29b. Signature and title of certifier

(Check only one)

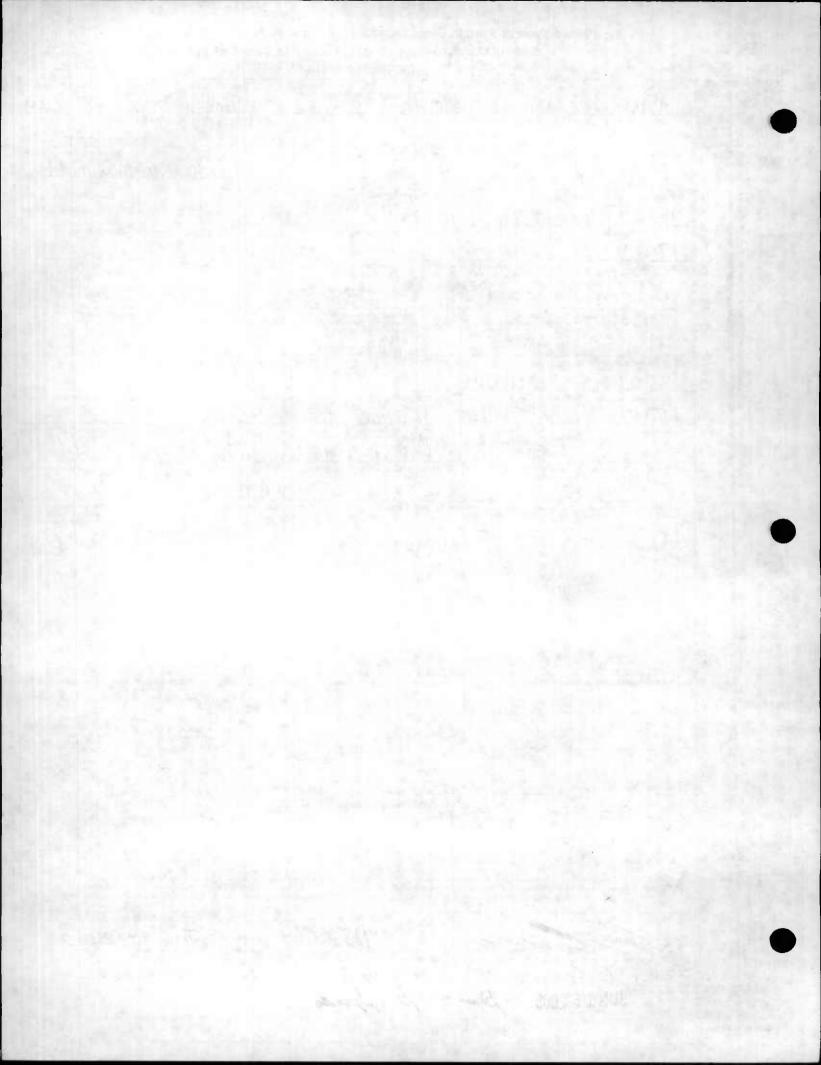
15201 Shedy 32. Registrar's Signature

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

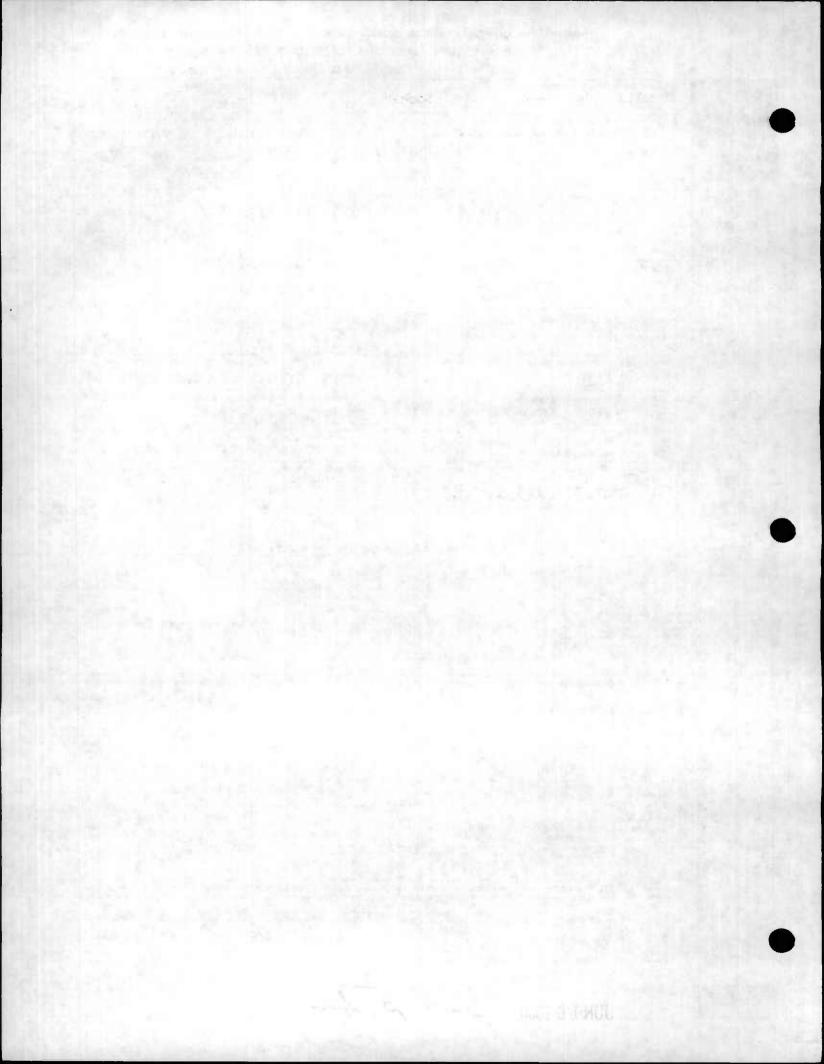
29d. Date signed (Month, Day, Year)

Road Rockettle MO 20850



State of Maryland / Department of Health and Mental Hygiene 00 | 9 | 28

		Certificate of	Death	Reg.	No.	1 2 1 12 0
Physician	Decedent's Name (First, Middle, Last)     Cecelia Ann	Kocher		2. Date of Death Month	Day Yaar	3. Time of Death
/Medical	4e Facility Name (If not institution, give street and number)	ROCHEL	4b. City, Town, or Loca	June 14,	2000 4c. County of Deat	8:45 pm
Examiner	Mariner Health of Glen Bur		Glen Burn	nie	Anne Ar	undel
uneral irector	016 00 4014	92 Yrs. Hest birthdey) If Under 1 Yee Months Day.	Hours Min.	Date of Birth (Month, Day, You October 26	ear) Co	hplace (State or Foreign untry) MD
B ==		Oc. City, Town or Location				10d. Inside City Limits
outled	MD N/A	Law 7: 0 .	Baltimore	-	0	MYes 2□No
on must be notified at uneral Director	928 South Streeper Street	10f. Zip Code	21224		Citizen of What Co United Sta	
by F	11. Marital Stetus  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Eve Armed Forcas?  1 Yes 2 No it Yes, Give Year or Dates:	r in U,S. 13. Was Decedant of If Yes, specify Cu	Hispanic Origin? (Speci ban, Mexican, Puarto Ri o Specify:	fy Yes or No- can, atc.)	14. Raca - Ame Black, White Specify:	
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occ (Give kind of work don	e during most of working	16	b. Kind of Business/	industry
du	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retii	red)			
ပိ	3 0	Fact	Ory Worker  18. Mother's Name (		Manufactu Iden Sumame)	ring
o Be	Martin Mrozinski		Catherin		and the second	
-	19a. Informant's Name/Ralationship (Type, Print) Diane Taylor / Grandchild	19b. Mailing Address (Stree 1114 East F			*	(ip Coda) 1230
once.  To Be Completed To Be C	AFTER LA GEO CONTRACTOR AND	20b. Place of Disposition (Name of cemetery, crematory or other p Saint Stanislaus Ceme	etery June19,		c. Location · City or Baltimore Ma	
DUC.	21. Signeture of Funerel Service Licensee Victor P. I	unaries L.	ress of Fecility Stevens Funera Fort Avenue, B	al Home, I	inc. Faryland 21	230
	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each lina.	e death. Do not antar the mode of d	ying, such as cardiac or	respiretory errest	,	Approximate Interval Batween
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100	resulting in death)	e to (or as a consequence of):	0			0
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Medical	Cause (Disease or injury that Initiated events resulting in deeth) Last	e to (or as a consequence of):				
Physician	Part II. Other eignificant conditions contributing to death but n	ot resulting In the underlying cause	given in Part I.	23b. Did toba	eco use contribute	to the cause of death
y Phy	Hypothyvi dism			1 🗆 Yee	2□ No 3□ P	robably 4 Unknow
Be Completed by				24a. Was an a performe	d?	Were autopsy findings available prior to completion of cause of death?
Com				1 ☐ Yes	2000No	1 □ Yes 2√√No
Se C	25. Was case reterred to medical		26. Piaca of Death (	(Check only ona)		
To T	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient 3 DOA	Othar: Wursing Home	e 5 Residanc	ca 8 Othar (Spe	city)
led in by the funera Certification:	27. Mannar of Death  → ₩ Natural 2 □ Accident  28a. Date of fnjury (Month, Day Yo		ury at 28 ork? □ Yes 2 □ No	ld. Describe how	injury occurred	
Sertifi	3 Suicide 6 Could not be determined 28e. Placa of Injury building, atc. (5	e 28	If, Location (Stree City or Town, S	et and Number or Ri State)	urel Route Number,	
oompletely filled in Medical Cert	29a. Cartifiar (Check only one)  XX Certifying Physician: To the best of m 2 Medical Examiner: On the basis of axi and manner stated	amination and/or investigation, in my				
completely filled in by the Medical Certifica	29b. Signature add title of certifier		nsa number	29d	. Data signed (Mont	h, Day, Year)
	> / he of owy has	D	40521	-	June 16, 20	000
5	30. Name and address of person who completed cause of death  DR. O CHANET	h (Item 23a) (Type, Print) 335	o Wilkens		Snite	302
State	31. Date filed (Month, Day, Year) 32. Registrat's	Signature	-1 T	001		
Registrar	ILINIA & 2000 Be	wa & Spo	uls			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Year Physician 8:50 A.M. Jackie Ray Ketterman JUNE 14,2000 /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Square Baltimore ROSedone Franklin HOSP, tal Center If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Deys 1 M 2 □ F Yrs. 233-52-0035 67 Director Oct.27,1932 W.V. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or itema 23a or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Dundalk 1 ☐ Yes 2 ☐ No Director Md. Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8271 Del Haven Rd. 21222 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2X Merried 1 Yes 2 No White Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) 12 yrs. College (1-4or 5+) permit. Peges 1 and 2 should be filed w
Department of Heelth and Mental Hygien
Important: If item 27 is marked other tha
any injury or other traumatic acceptance. Dispatcher Can Co. 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Raymond Daniel Ketterman Helen Martha Sponaugle 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Annette Ketterman 8271 Del Haven Rd. Dundalk Md. 21222 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from Stete June 1 2000 4 ☐ Donation 5 ☐ Other (Specify) Christ Luth. Cem. Dundalk 21. Signature of Funcial Service 10 22. Neme end Address of Fecility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 Approximate Intervel Between Onset end Deeth 23a. Pert1. Enter the risclese, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear risclese, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear risclese, or complications that cause the deeth. **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical a. Multiple Myeloma

Due to (or es a consequence ot): 4 years Examiner Examiner burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): and nding physician a Physician/Medical that initieted events resulting in death) Lest Due to (or es e consequenca ot) Pert ff. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t þ 24b. Were eutopsy findings evailable prior to completion of cause of death? Be Completed 24e. Wes an eutopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifical stelly filled in by the funeral director; 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Injury 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and pleca, end due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier

Box 68760 Records, P.O. Division of Vital

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Ketternan

Tackie

Baltimore, Maryland 21215-0020

To the Hospital of within 24 hours a To the Funeral D completely filled in a second completely filled in the second completely

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State Registrar 29b. Signeture end title of certifier

31. Date filed MAN. Pay 6 2000

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30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32 Registrar's Signeture

Jan D

MEN (M.D.) 68-30 HORPHTAL DQ. # 206, BALTIMORE, MD 21237

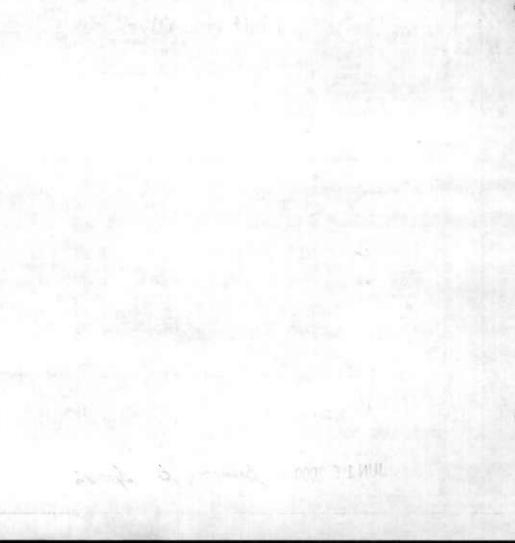
6/14/00

29d. Date signed (Month, Day, Year)

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29c. License number

D-15390



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Kowalevich Day Month **Physician** alter 11:00 Anh 12 8000 JUNE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Canton Harbor N/A Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Feb. 14, 1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Days Months Hours Country) Md 10 M 2□ F Yrs. 213-03-8024 81 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or ferms 23s or 28s-f show traumatic event, the Medical Examinar must be notified at Md. Baltimore Eastwood 1 ☐ Yes 2 No Funeral Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 7004 Bank St. 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marifel Stefus 1 Yes 2 No If Yas, Give Yaar or Datas: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 yrs. Mechanic Steel permit. Pages 1 and 2 should be file. Department of Health and Mental Hy, important: If Nem Z7 Is marked othe any Injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ephraim Kowalevich 10 Dora Kowalevich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Kowalevich 7004 Bank St. Baltimore Md. wife 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 1 t Banial 2 Cremation 3 Ramoval from Stata Holy Trinity Elkridge 4 Donation 5 Dollar (Specify) 2 Signature of Fungral 22. Neme end Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 muz, Approximete Interval Between Onsat and Death clused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, such line. **Physician** enocarcinoma of ( /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine Sequenfially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician t the bural Physician/Medical Due to (or as a consequence of) a de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yee 2 No 3 Probably 4 Unknown à 2 24a. Was an autopsy performed? 24b. Were autopsy findings aveilable prior to complation of cause of daath? Completed certificate has 1 Yes 2 No 25. Was cesa rafarred to medical examiner? Be 26. Place of Daath (Check only ona) To Hospital: 1 Inpatient 2 ER/Outpatienf 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No His se funeral Certification: 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Dascribe how Injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accidant 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be detarmined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) B 4 I Homicide edical 1 Certifying Phyeician: To the best of my knowledga, daath occurred at the time, data and place, and due to tha causa(s) and manner as statad. 2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier

Box 68760 Division of Vital Records, P.O. that The law requires

with the Maryland

filed within 72 hours after

Saltimore, Maryland 21215-0020

Physician: al or Attending P after death. I Director: After within 24 hours of To the Funeral Completely filed ž

State Registrar 31. Date filed (Month Pay, Year) COO

(Check only one)

29b. Signeture and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohamma 2 Ali Ansari Lari Johns 32. Kegistrar's Signature

Johns Hapkins Hospita

29c. License number

P9016

29d. Date signed (Month, Day, Year)

2000

To the last of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death Day Yae **Physician** KINESLE JEORGE 10:30 a.M une 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner Count Columbia Mal Howard Howard Birthplaca (Stata or Foreign Country) If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 55 DEM 2DF .36.02 New York Director Usual Rasidence of Decedant with the Meryland 10a Stete 10d. Insida City Limits 10b. County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Exeminer must be notified at 1 Yas 2 XVo Funeral Director Maryland Ellicott City Howard 10g, Citizen of What Country? 10e. Sfreef and Number 10f. Zip Coda ò 21042 U.S.A 3517 Coventry Court Drive or items 23s Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 12. Was Decedent Evar in U.S. Armed Forces? 11 Marital Status Black, Whita, atc. filed within 72 hours after TYAS GIVA 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No White Specify: Specify Be Completed by 3 ☐ Widowed 4 ☐ Divorced ERA Yaar or Datas: natural', 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry al Hygiene. U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) Attorney 5+ 17. Father's Nema (First, Middla, Last) 18. Mothar's Neme (First, Middle, Maidan Sumama) Pages 1 end 2 should be 1 Department of Health and Mental in Important: If Itam 27 is marked of any injury or other traumatic eve Constance Redmond George D. Kingsley 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 3571 Coventry Court Drive Ellicott City, Maryland 21042 Mrs. Sally Kingsley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Critimation 3 Ramoval from Stata
4 Docation 5 Other (Specify) 06/14/00 Sykesville, Maryland All County Cremation Services, Inc. signatura of Funaral Service License 22. Name and Address of Facility Slack Funeral Home, P.A. bele 3871 Old Columbia Pike Ellicott City, MD 21043 MUOS Var11. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiec or respiratory arrast shock, or heart tellure. List only one cause on each line. Approximata Intervat Batwaan Onset and Death **Physician** Immediata Causa (Final disaase or condition resulting in daeth) /Medical PERFORATION Examine Dua to (or as a consequence of) Physician/Medical Examiner tastakic Melenom The law requires that the death certificate be executed the bunst-transit Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Diseasa or injury that initiated evants rasulting in death) Last Due to (or as a consequence of) Box 68760, nentensis Dua to (or as a consequanca of) r use es t P.O. 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 2 X No ate hes been signed by page 2 should be detacl 1 Yes 3 ☐ Probably 4 ☐ Unknown of Vital Records, Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? complation of cause of death? certificate hes 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: funeral director. 25. Was case raferred to medical axaminar? Medical Certification: To Be 26. Piaca of Death (Chack only one) 1 Yas 2 No Hospital: 1 ☐ Inpatiant Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) ER/Outpatient 3□ DOA After this 28a. Data of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Division 5 Pending invastigation 1 ☐ Yas 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datarmined 3 Suicida 28e. Placa of Injury - Af homa, farm, street, factory, office building, etc. (Specify) filled in by 4 D Homicida Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

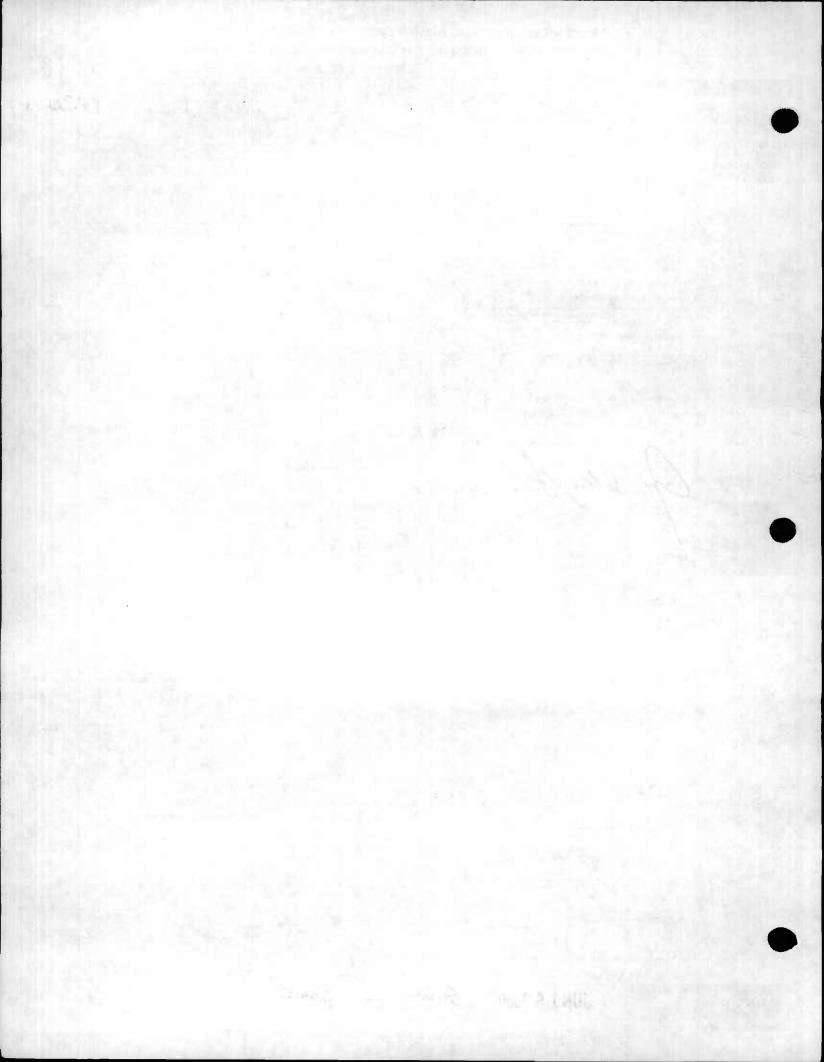
— Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier completely 29b. Signetura and fitte of certifit 29c. Licensa number 29d. Deta signad (Month, Day, Year) 2000 30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print) PIRE, ELLIGHT CITY -- 10298B WD CHIO 31. Data filed (Month, Day, YUN 1 6

Registrar DHMH 16 Ray 6/95

State

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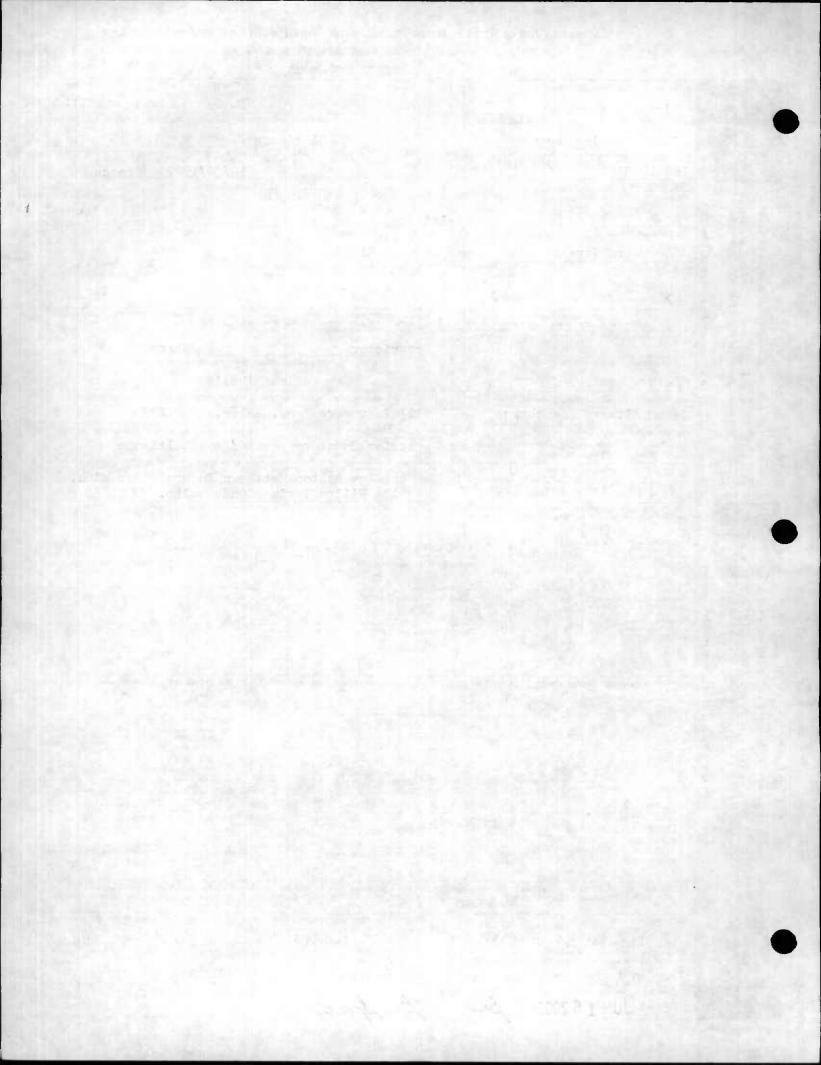


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 3. Tima of Death 2. Date of Death Day Month Year **Physician** June 2000 7: 10 PM 10 Michael Kametses /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hopkins Bayview If Under 1 Year If Under 24 Hrs Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours 1XM 2□ F Yrs Director 168-10-5402 10/24/1907 Greece Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Maryla Yes 2 No Directo "natural", or lisms 23a or 28a-f MD d 2 should be filled within 72 hours atter death with the Mith and Mental Hygens.
The model other than "nature", or ferms 23s or 28s-f trauments ovent, the Medical Examinar must be notified. Baltimore 10g Citizen of What Country? 10e Street and Number 10f. Zip Code 704 Umbra Street 21224 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yea or No-If Yea, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Meritel Status 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Proprietor Bakery 18. Mother's Name (First, Middla, Maidan Sumama) 17. Father's Name (First, Middla, Last) 89 Pages 1 and 2 should be nent of Health and Mental Peter Kametses Zafira Mikedis Department of Health and M. Important: if Item 27 is mark any Injury or other transment. 19a. Informant's Name/Retationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Renne Altzas Daughter 8317 Sagramore Road. Balto. MD 21237 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition Date St Demetrius Cemetery 1. Burial 2 Cremation 3 Removal from State 06/13 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
Bradley Ashton Matthews Funeral Home, Inc. 21. Signature of Funeral Service Licensee Trecas 2134 Willow Spring ROad, Balto. MD 21222 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Arterioschotic Coronary Artery Disease 10 years disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): and attending physician for use as the buria P.O. Box 68760. The law requires that the death certificate be Physician/Medical Due to (or es a consequence of): signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed peen a 99 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only ona) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Manner of Death 26a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation ours after death. eral Director: Affilled in by the ful 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD ala. Um 20313 15,2000 Cr 30. Name and address of parson who completed cause of death (Item 23a) (Typa, Print) 21224 4940 EASTERN AVE BALTIMORE DAVID A. RAPKO. JOHNS HOPKINS BAYVIEW 31. Dete tiled (Month, Day, Year) 32. Registrar's Signature State JUN 1 6 2000 Registrar

**DHMH 16 Rev 6/95** 

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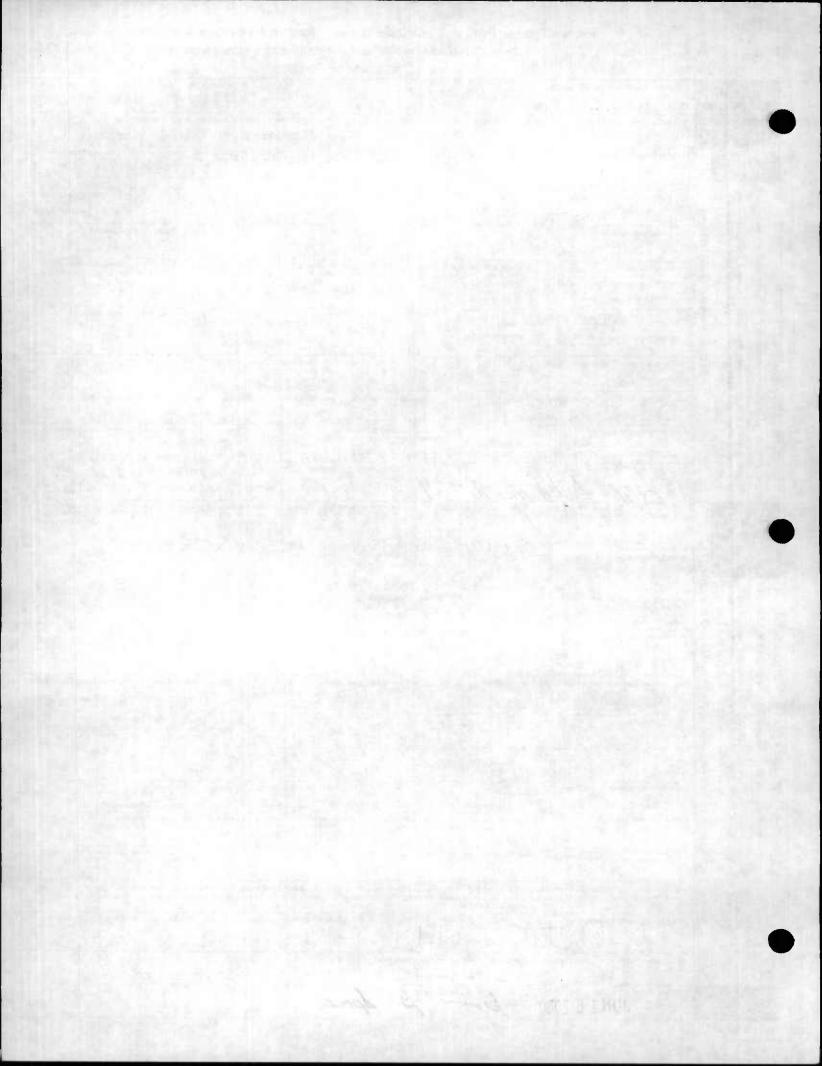


State of Maryland / Department of Health and Mental Hygiene

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109. Street and Number 107. Zip Code 149 HILLENDALE LANE 37615									Citizen of \	What Count	ry?		
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3 ☐ Widowed 4 ☐	100 100 100	If Yes, Giv Year or D	e		1 🗆 Yes	2 🔯 No	Specify:				Specify	y: WHITE	
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17. Father's Name (Firs	st, Middle, Last)						18. Mothe	er's Name	e (First, Mic	idle, Mai	den Suman	ne)	
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4 Donation 5			Ba:	ltimore									
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A PARTIES										∐ Yaa	2□ No	3 Prob	ably 4X Unknow
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2 Accident investigation M 1 Yes 2 No					No								
3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Piece buildin	of injury - At h ng, etc. <i>(Speci</i>	ome, ferm, str	reet, facto	ry, offica				on (Stree Town, S		ber or Rural	Route Number,
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(Check only one)  22 Medical Examiner: On the basis of examination and/or investigated and manner stated.							se number			29d.	Date signe	d (Month, E	Day, Year)
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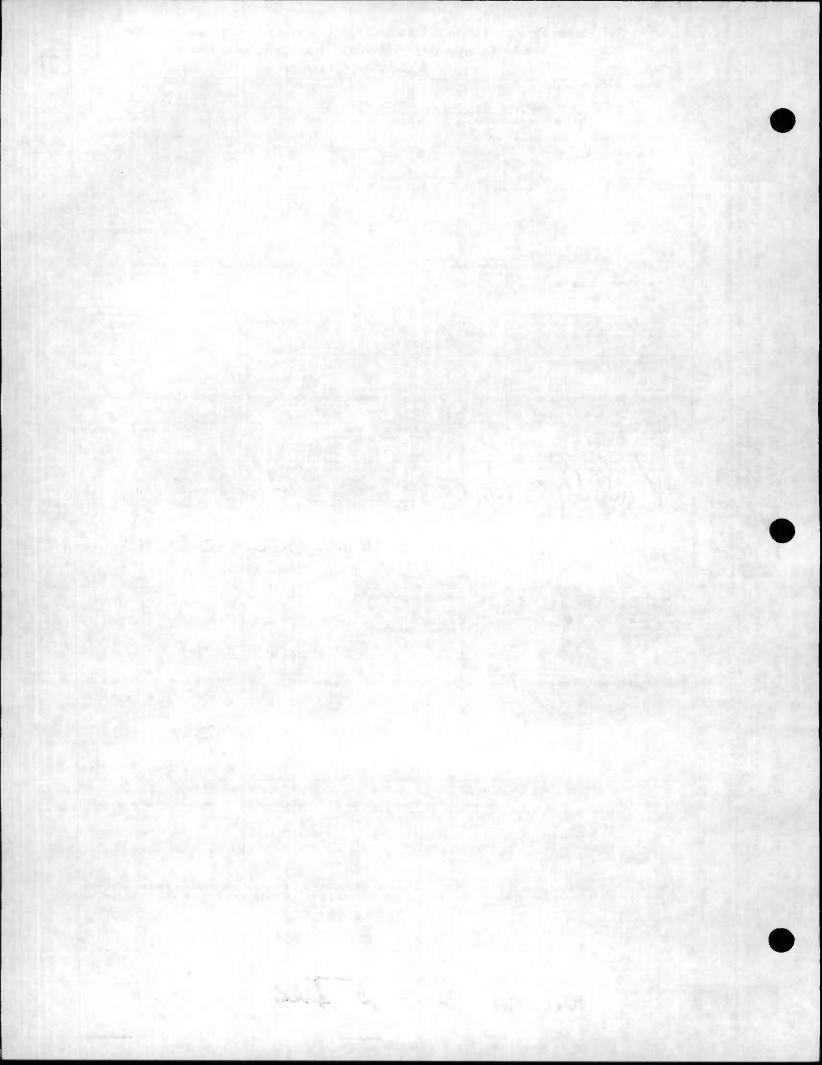


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** June 13,2000 Thomas Linthicum Jefferson 1652 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Yeer | If Under 24 Hrs. | Months | Days | Hours | Min. 6. Sex XXM 2□ F 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 220-36-5991 60 March 1, 1940 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 28a-f Anne Arundel Annapolis 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or litering 23s or 917 Poplar Avenue 21401 USA death Funeral 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mertal Hygians. Insportant if fem 27 is merked other than "natural", or lies any injury or other traumatic avant the Mantinel Femilians 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White aitimore, Maryland 21215-0020 1 ☐ Yes 2 H No Specify. þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Security Officer Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Thomas Jefferson Linthicum III Miriam Edith McKee To 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Linthicum (Wife) 917 Poplar Avenue, Annapolis, MD 21401 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 06/17 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Cedar Bluff Cemetery 2000 Annapolis, MD of Fungral 5 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heer feiture. List griy one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final ABDOMINAL ADRIC ANEURYSM disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner typictening ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Box 68760. Physician/Medicai typerlegislemin Due to (or as a consequence of) for use as dependent dialities mellitus P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ of Vitai Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? page 2 should Medical Certification: To Be Completed certificate has 1 Yes 1 Yas 2 No or Attending Physician: 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending rispurations within 24 hours after deeth.

To the Funeral Director: After this of the Funeral Directors of the funeral directors and the funeral directors. 1 Yes 2 No 2 SER/Outpetient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Division 1 Setural
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 14, 2000 30. Name end address of person who completed cause of death (ftem 23a) (Type, Print) MeD., 600 DOELY-AVE, ANNAPOLIS, MD. OBERT 32. Registrar's Signature 31. Dete filed (Month, Dey, Year) JUN 1 State Registrar

**DHMH 16 Rev 6/95** 

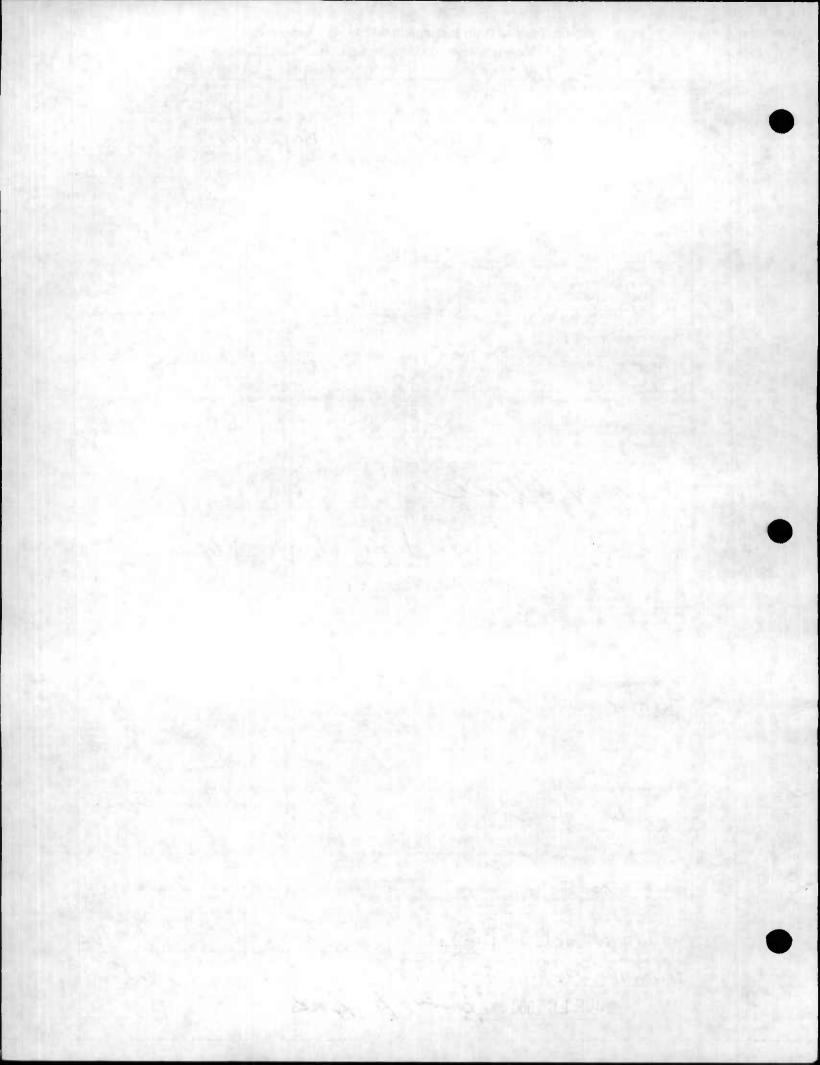
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Honth **Physician** 00:10 CATHERINE E. LIPSCOMB 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 139/1 Health Gnes Care mo N/A If Undar 24 Hrs. 5. Social Security Number If Under 1 Yaar 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (Steta or Foreign Country) Funèral Days Months 1□M 2\ F Hours 217-09-1573 Director 88 MD July 24, 1911 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mental Hygiene. Int: if Item 27 ie marked other than "natural", or items 23s or 28s-f show 10a. State 10b. County 10c. City. Town or Location 10d, Inside Clty Limits the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Baltimore Catonsville Funeral Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 16 Fursting Avenue 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ѽ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2♥ No Specify: Specify: white Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) housekeeping unk 18. Mother's Nama (First, Middle, Maiden Sumeme) unk 17. Fathar's Name (First, Middle, Last) John E. Price Agnes A. Brown 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Numbar, City or Town, Stete, Zip Code) Department of Health er Important: if item 27 is any Injury or other trat-pace. Viola Hynes/friend 801 Woodsdale Road Baltimore, MD 21228 20b. Place of Disposition (Nema of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, cremetory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Euneral Sphool Licensee ROPALD S. Wade 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) One das Examiner Physician/Medical Examiner N2 415 nev Tensiv Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be exec Dua to (or as a consequanca of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? page 2 should Completed certificate has 1 Yes 1 Yes Vital Hospital or Attending Physician: 25. Was case referred to medicat examiner? oscomb Medical Certification: To Be 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No After this 27. Manner of Death 12 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. 1 Yas 2 No 6 Could not be 3 Suicide 28f. Location (Straat end Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Dey, Year) 00 of death (Item 23a) (Type, Print) 9/timore 1 SNY 31. Date filed (Month, Day, Year)
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 19136

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Deeth Month June 13, 2000 12:20pm William McDaniel 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 1333 Ramsey Street Baltimore NA 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03-31-31 Birthplece (State or Foreign Country) W 2□F Months Davs Hours 69 Yrs. 214-26-7086 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1333 Ramsey Street 21223 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2□ No Specify: Specify 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Care Elementery/Secondery (0-12) College (1-4or 5+) 6th Grade Housekeeping Crothail Health 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Jim McDaniels Pearlene Thompson 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21213 Mona McDaniels 3922 South Clare Road Baltimore, MD. 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Voshell Mem. Gardens 06-19-2000 Dundalk, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funerel Service Licensee WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset end Death Immediate Cause (Final Month disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequença of): Due to (or as e consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy 2 0 No 1 Yes 2 No 1 Vas 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Mesidenca 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how Injury occurred 1 Yes 2 No

Examiner physician and s the burial-transit The law requires that the death certificate be executed Physician/Medical 980 þ Be Completed Physician: Certification: To this

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Important: If It any injury or o

Examiner

Department

the Maryland

death

1 Yes 2 No 27. Manner of Death 1 Maturel

25. Wes case referred to medical

5 Pending Investigation 2 Accident 6 Could not be 3 ☐ Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name and address of persoq who completed cause of death (Item 23a) (Type, Print)

821 ST +305 BALTIMORE MO2124 ALLISHNAN NIEUTAN 1. Dete filed (Month, Dey, Year)

State Registrar

edica

29a. Cartifier

JUN 1 6 2000

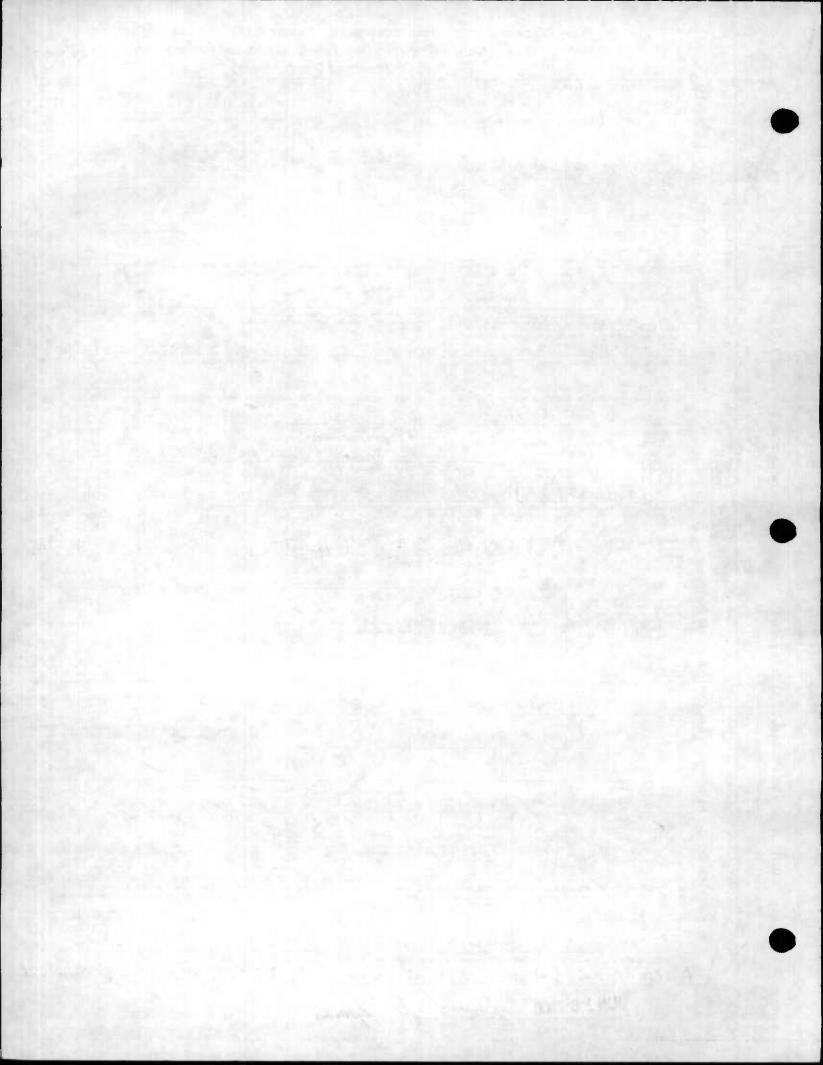
32. Registrar's Signeture

Pages 1 and 2 should be filed within 72 hours after not of Health and Mental Hyglene. not if them 27 is marked other than "natural", or its ny or other traumatic avent, the Medical Essention. 3altimore, Maryland 21215-0020 **Physician** P.O. Box 68760.

Records, Division of Vital

Hospital or Attending Pi 24 hours after death. Forestal Director: After the within 24 hours To the

DHMH 16 Rev 6/95



	Oc PER FH G				Certificate of	Death		g. No.		9138
hysician	1. Decedent's Na	me (First, Middle,		itchell			2. Date of Death Month	Day	Year	3. Time of Deeth
/Medical	rercy	(If not institution	give street and numb			4b. City, Town, or Lo		13, 20 4c. County		12:20am
xaminer			Homewood	61)		Baltimor		NA NA		
neral	5. Social Security		6. Sex 7.	Age (In yrs. last birth	nday) If Under 1 Yea	r If Under 24 Hrs.	8. Dete of Birth	Vacal	9. Birthplace	e (State or Foreig
tor	214-26 Usual Residence		1 □ M 2 □ F	71 Y	rs. Months Days	Hours Min.	(Month, Day, 01-31	-29	Country)	sc
Olrector	10a. State	10b. County		10c. City, Town	or Location				10d.	Inside City Limit
ctor	MD	N.	A	Balti	more			133		1 Nas 2 Nas
Directo			ne Avenue		10f. Zip Code 212	205	10	g. Citizen of V USA	What Country	?
eral			12. Wes Decede			Hispanic Origin? (Spetan, Mexican, Puerto	ecity Yes or No-		ce - American	Indian,
Funer	1 Never Ma	rried 2 Marrie	Armed Force	96?			Rican, etc.)	Biad	ck, White, etc.	
À		4 Divorced	If Yes, Give Year or Date	is:	1 ☐ Yes 2/ONNo	Specify:		Specify	Blac	ck
Completed	(Spe	15. Decedent's ecify only highest	Education grade completed)	16a. C	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	upation during most of worki	ing 1	6b. Kind of Bu	usinass/Indua	try
dm	Elementary/Sec		College (1-4	or 5+)	ille. DO NOT use retire Foreman	90)		A rmco	Steel	l Co
					roreman	18. Mother's Name				
o Be	T4			tchell		Florence			itchel	11
-	19s. Informant's I	Name/Relationshi	ip (Type, Print)	19b.	Mailing Address (Stree	et and Number or Rura	al Route Number,	City or Town,	State, Zip Co	de) 2120
	Marsha	Ro:	ney	90	6 N. Mont	ford Ave	enue Ba	ltimo	re, Ma	aryland
	20a. Mathod of Di		По и о	cemeten/	Disposition (Name of cremetory or other plant	a.ce)	Date 2	Oc. Location -	- City or Town,	State MD.
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8	21. Signatura of F	Funeral Service L	cechen		22. Name and Addr		ltimore			21202
8	1 /08	nully	Make	)	WM.C.Man	rch FH 1				
	23a. Parti. Erner	the disease, or s	that cause on each	sed the death. Do no	ot enter the mode of dy	ring, such es cardiac c	or respiratory erre	st,	Ac	proximate tarval Between
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	Immediate Cause disease or condit	ion	(	erebro V		1	1			
	Ciococo oi conon			ered in	asular	recour	LE		1	
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State Registrar

31. Date filed (Month, Day, Year)



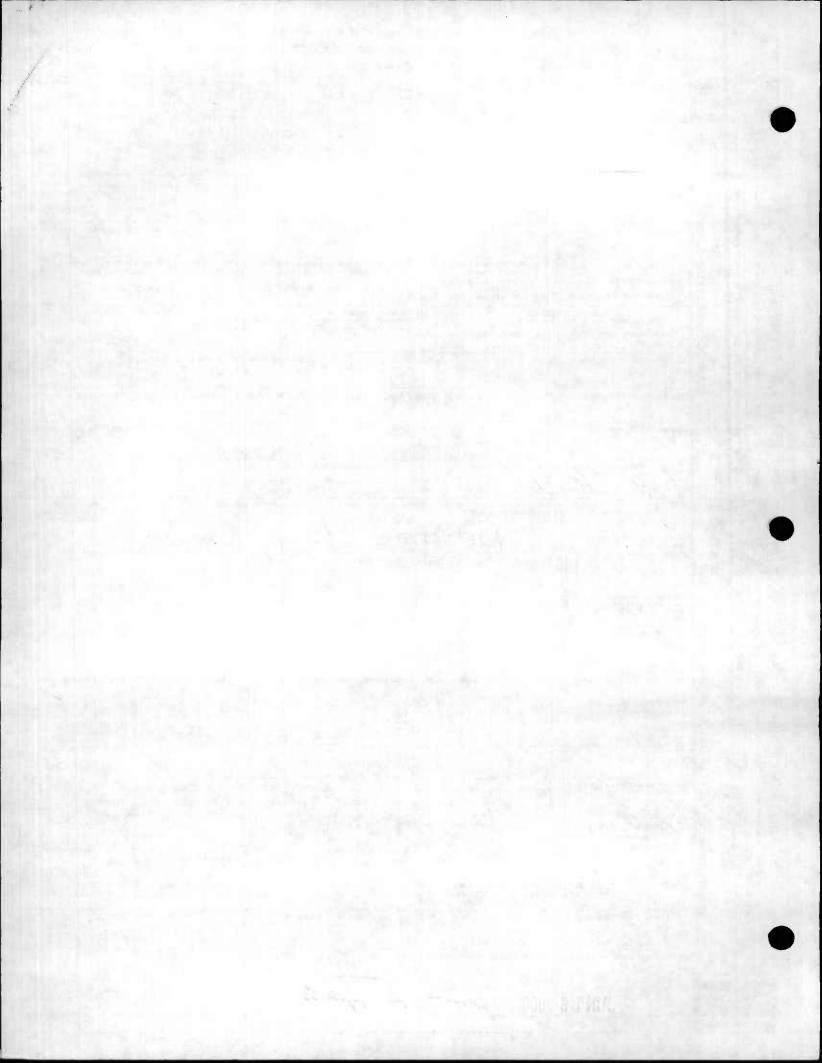
DHMH 16 Rev 6/95

**ORIGINAL** 

A. J. J. J. J. J. Leeve to The state of the s

State of Maryland / Department of Health and Mental Hygiene amend item 5 per fh G785 7/27/00 yg Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Dev Month Year **Physician** Virgil Joseph Molitano 5:12 AM /Medical Jun 10, 2000 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City St. Agnes Nursing & Rehab Center Howard If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 107–18–8045 Birthpiaca (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Months 10M 20F Yrs. Director 100188045 Aug 31, 1925 New York Usual Rasidence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director 28a-f Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 23a 4702 Parkvale Road 21043 U.S.A Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Insportant: If them 27 is marked other than "natural", or that any Injury or other traumatic event. the Medical Control Black, White, etc. 1 Never Married 2 Married X 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1943 1 Yes 2 No Specify: ğ Specify. 3 Widowed 4 Divorced White 1946 Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Alcan Aluminum Office Manager 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be 2 Augustino Molitano Virginia Giglioli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 3049 Berkshire Court Waldorf, Maryland 20602 Mr. Edward J. Molitano 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removal from Stata
4 Denetion 5 Other (Specify) 06/13/00 Marriottsville, Maryland Crest Lawn Memorial Gardens satura of Funeral Service Licer 22. Nama and Address of Facility Slack Funeral Home, P.A. el 3871 Old Columbia Pike Ellicott City, MD 21043 14005)5 Paul 1. Enter the disease or complications that caused the death. Do not enfer the mode of dying, such as cardiac or respiratory arrest, albeck, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Daath **Physician** Immediate Causa (Final di wasa or condition rasulting in death) ETASTATIC /Medical Examiner Dua to (or as a consequence of) Examiner physiclan and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Records, P.O. Box 68760, physiclan Physician/Medicai Due to (or as a consequence of): for usa as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? s been signed by t should be detact 3 Probably 4 Dehknown 1 ☐ Yaa 2 ☐ No þ 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy page 2 s 1 Yas 2 No certificate 1 Yes 212 No Division of Vitai or Attending Physician: funeral director, 8 25. Was casa rafarred to medical 26. Place of Deeth (Check only ona) Other: Nursing Homa 5 Rasidence 6 Othar (Specify) Medical Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Deta of tnjury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Affer 5 Pending invastigation Natural death. 1 ☐ Yas 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be detarmined 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated.

| Certifying Physician: To the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and mannar stated. 29a. Cartifia completely (Check only one) within 2 \$ 29b. Signatura and titla of certifier 29d. Data signed (Month, Day, Year) 29c. License number lluan 10 D28595 ueli 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Lakhani, Tasneem 7220 Park Heights Ave. Baltimore, MD 21208 31. Data filed (Month, Day, Year) 32. Register's Signeture State JUN 16 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death June 14, 2000 **Physician** 6:55 AM Catherine F. Marshall /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Timonium 8. Date of Birth (Month, Day, Year) September 1, 1934 Maryland If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Houra 10M 20F 65 216-30-6919 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28s-f show with the Maryts 1 Yes 2 No Baltimore **Baltimore** Funeral Director the Medical Examiner must be notifi-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2422 Poplar Road 21221 U.S.A. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? Race - American Indien, Black, White, etc. 11. Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or he say injury or other traumatic event, the Medical Exuation 1 Yea 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1□ Yes 2□ No altimore, Maryland 21215-0020 Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Langhirt Josephine Mueller 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2422 Poplar Road Baltimore, Maryland 21221 Mr. Kenneth J. Marshall- Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete Hilltop Service Corp. 6/15/00 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme and Address of Facility Leonard J. Ruck, Inc. Heather Cain 5305 Harford Road Baltimore, Maryland 21214 Las OK M 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Metastatic Lung /Medical Immediate Ceuse (Finet disease or condition resulting In deeth) Examiner Examiner sician and burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted eventa resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Thunknown þ 24b. Were autopsy tindings available prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Dothar (Specify) HOSPICE Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner ateted. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier D43725 6/14/00

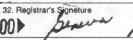
State Registrar

**DHMH 16 Rev 6/95** 

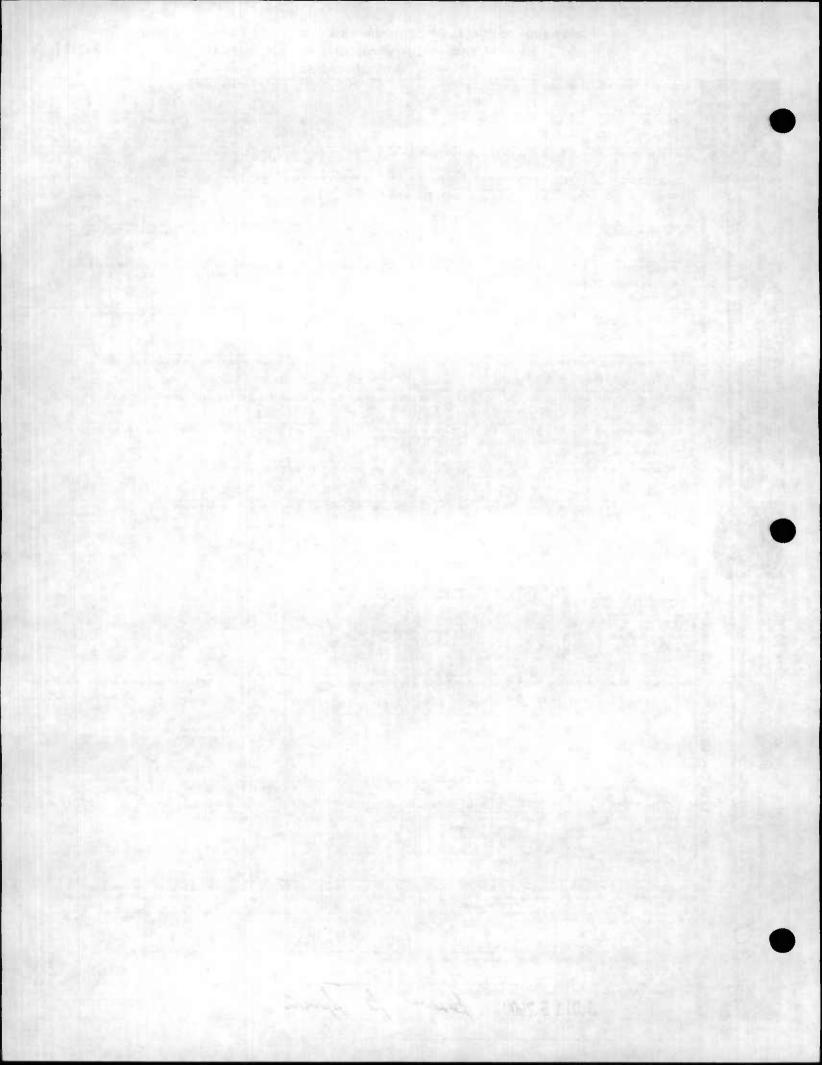
31. Date fited (Month, Day, Year) JUN 1 6 2000

IARIO MAHMOON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



201-109 Back River Neck Road Baltimore MD 21221



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year MARY C. MILLER June 9, 2000 2106 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year Sept 5, 19 Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1□M 2| F Yrs. 215-26-9550 69 1930 MD Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Allegany Barton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21521 USA 19604 Sugar Maple Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanto Ortgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Ñ Nevar Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) (Give kind of work dona during most of working lifa. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 12 4 teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname)

Mary D. O'Neil

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Barton, MD

21521

22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street

20c. Location - City or Town, State

29d. Data signed (Month, Day, Year)

7 is marked other than "natural", or herns 23a or 23a-f traumatic event, the Medical Examiner must be notified filed within 72 hours after Baltimore, Maryland 21215-0020 and Mental Hygie is marked other permit. Pages 1 and 2 should be I Department of Health and Mental I Important: If Item 27 is marked of

**Physician** 

/Medical

Examiner

Director

Funeral

ğ

Completed

Be

10e State

MD

Edward S. Miller

20a. Method of Disposition

21-Signature of Funeral Si

19a. Informant's Name/Relationship (Type, Print)

David L. Miller/brother

4 Donation 5 Other (Specify)

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State

Ronald S. Wade, Director

**Funeral** 

Director

**Physician** /Medical Examiner

Examiner The law requires that the death certificate be exec

been signed by the attending physician and should be detached for use as the burial-transit Physician/Medical by Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 8 Certification: To

certificate

/ WILLIAM / 10	Baltimore, MD 2120	)1
23a. Part1. Enter the disaasa, or complete, or heart failure. List only of the complete complete complete complete complete condition resulting in death)	a. Metab Lic Encephario pue to (or as e consequence of):	or raspiratory arrest, Approximate Interval Batween Onset and Death  Aparthy  Approximate Interval Batween Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseasa or injury that initieted events resulting in death) Last	b. Advance Lives Cirris  Due to (or es a consequenca of):  c	asis Unknown
	ontributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco uss contributs to the causs of death?  1 Yes 2 No 3 Probably 4 Unknown
Breast Mi	ass, Bleeding dialters	24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of causa of death?  1  Yes 2 No 1 Yes 2 No
25. Was case rafarred to medical	26. Place of De	ath (Check only ona)
axaminer? 1 Yes 2 No		dome 5 Residenca 6 Other (Specify)
27. Mannar of Death  1 Natural 5 Panding invastigation	28a. Data of Injury (Month, Day Year)  28b. Tima of Injury Injury  M  28c. Injury at Work?  1 □ Yes 2 □ No	28d. Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)	281. Location (Street and Number or Rural Route Number, City or Town, State)

Box 90

20b. Place of Disposition (Name of cemetery, crematory or other place)

**DHMH 16 Rev 6/95** 

Division of Vital Records, P.O. Box 68760,

State Registrar

edical

31. Date filed (Month, Day, Year)

29b. Signature and title of corp.

29a. Certifier (Check only one)

6

. Khann

32. Registrar's Signature

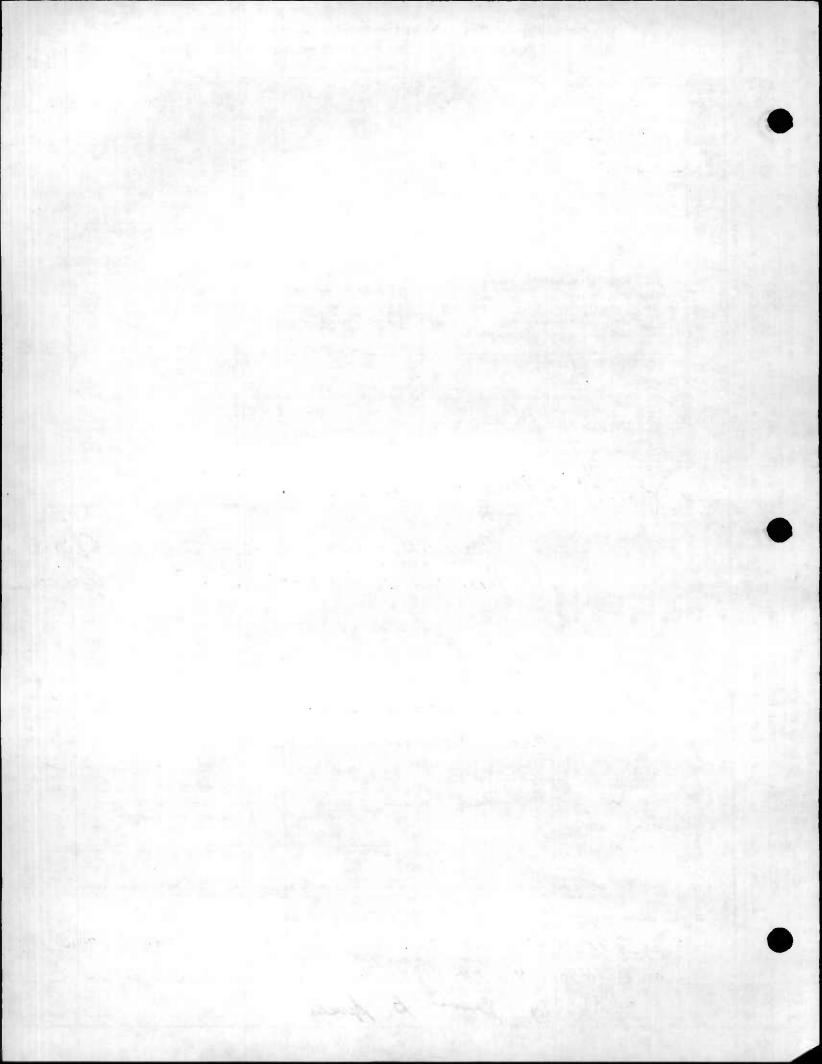
who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. Licansa number

umberland



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month CG 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE If Undar 1 Yaar 5. Social Sacurity Number 7. Age (In yrs. lest birthday) 8. Sax If Undar 24 Hrs. Birthplaca (Steta or Foreign Country) Days 1 M 2 F Months Hours VIRGINIA Usuei Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits BALTIMORE MARYLAND 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2813 E. FEDERAL STREET 21213 U.S.A. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, GiveX Year or Dates: AFRO -AMERICAN 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 7 TH College (1-4or 5+) CAFETERIA WORKER GOVERNMENT HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) ROSWELL LASHLEY MOLLIE EDMONDS 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) JOSEPH LASHLEY / BROTHER BALTO, MD. 1417 KENHILL AVE 20b. Place of Disposition (Name of cemetery, crametory or other plece) 20c. Location - City or Town, Stata 2000 OWINGSMILLS, MD. Date 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crametory or other place) GARRISON FOREST VET.CEM. 20 ature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME Part 1. Enter the disease, or complications that caused the death, Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. PRESTON ST. BALTO, MD. 21213 Approximate Interval Between Onset end Death Immediate Cause (Final diseasa or condition resulting In death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part ff. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Dementer sime Rument falls, 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28b. Time of 1 Naturai 2 Accident

**Physician** /Medical Examiner

The law requires that the death certificete be executed

or Attending Physician:

deeth.

After this

Division of Vital Records, P.O. Box 68760,

**Physician** /Medical

Examiner

Director

Completed by Funeral

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyla Department of Health end Mantal Hygiene.
Important: If Item 27 is merked other than "natural", or items 23s or 28a-f show any injury or other traumetic event, if a Madical Examiner must be notified at once.

Saltimore, Maryland 21215-0020

Examiner the ettending physician end hed for use as the burial-tren Physician/Medical þ Completed Be 7 Certification: To the Hospital or Attendi within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fo

25. Wes case referred to medical examiner?

1 Yes 2 No

3 Suicida

29a. Certifier

4 ☐ Homicide

(Check only one)

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Dey Year) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

Maryra C Raymunch 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 3007 E Northern Parkway

Paltergre MD 21214 MARTHA RACIMUNDO MD

31. Date filed (Month, Dey, Year)

JUN 1 6 2000

32. Registraris Signature

State Registrar

Medical

JUN 1 8 2000 Som & Somer

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

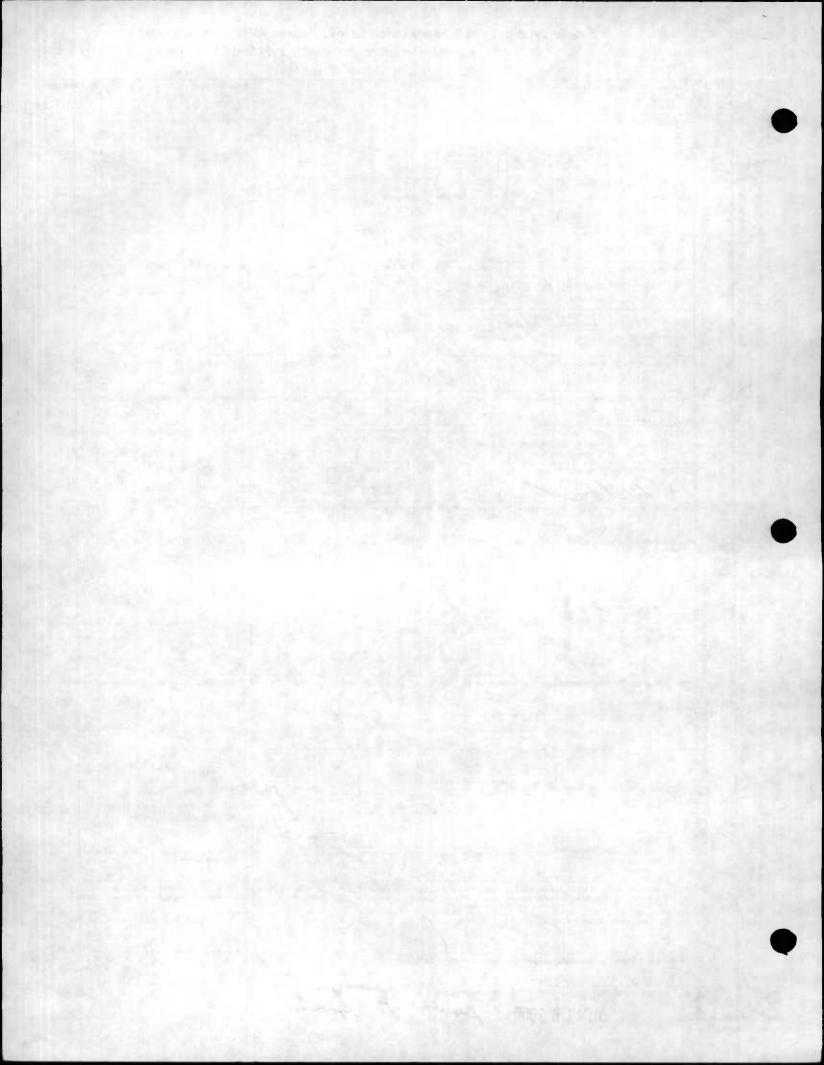
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ľ	5. Social Security	Number 6.	Sex 7. Ag	ge (In yrs. las		der 1 Year	If Under 24 Hrs Hours Min	8. Dafe of Bi	rth	9. Birthplace	(State or Foreign
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uneral Director	10a. State 10b. County 10c. City, Town or Location										Inside City Limits
octo	MD	-	BALTIMORE								1 PYes 2 □ No
nicer nust be notified Funeral Director	10e. Street and Number 10f. Zip Code 21218								10g. Citizen of \		
era	312 E.		12. Was Decedent		12 Wee De			Enacify Vac or N		a - American I	ndian
		rried 2 Married	Armed Forces?	?		_	lispanic Origin? (5 an, Mexican, Puer	to Rican, atc.)	Blad	ck, White, etc.	
		4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yas	2 No	Specify:		Specify	WHO	Ŧ
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Combiered by	Elementary/Sec	ecify only highest gi	College (1-4or	5+)	life. DO NO	Tuse retired	during most of wo d)	rking			
	12		+4		MEDICA	TL SE	ECRETAI			EALTH	
	17. Father's Name	e (First, Middle, Las	st)				18. Mother's Na	me (First, Middle	, Maiden Suman	ne)	
	JERG		BARI					HERINA		SSET	
		Name/Relationship			19b. Mailing Addr						de)
			ODEMSKI	, SIS	5 NORT	H STA	e cir.	SEZBYV	LLE M 20c. Location -	DE I	9975
	20a. Method of Di 1 Burial		☐Removal from State	cam	netery, crematory	or other plac	ce) i	JUNE 19			
		5 ☐ Other (Spec	**	DULA	ind run						
	21. Signature of F	Funeral Service Lice	ensee		22. Name	and Addre	ss of Facility	vans fi	NEEAL	CHAPE	2
	10	mon cy	17/		8800	HA	eford a	ED PAR	KVILLE		
	23a. Page . Enter	the disease, or cor sart failure. Vist of	polications that cause one cause on each li	d the death. ine.	Do not enter the n	node of dylr	ng, such as cardia	c or respiratory a	arrest,	Inte	proximate erval Between set and Death
	Immediate Cause	7/	//							. 011	Set and Death
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DHMH 16 Rev 6/95

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1110 Hallstead NOad   12-Was Decedent Ever in U.S.   13-Was Decedent of Hispanic Origin? (Specify Yes or No- In Place, White, acc.)   13-Was Decedent (Specify Place)   13-Was Decedent (S	Maryland Baltimore Parkville										1 ☐ Yes 2 N	
11. Marrial Status 1   New Potential Status 1												ntry?
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19a. Informant's Name/Reletionship (Type, Print)  Virginia Gale / Daughter  20a. Method of Disposition  All Durial 2 Generation 3   Removal from State    All Durial 2 Generation 3   Removal from State    All Constants 5   Cherric (Specify)    21. Signature of Funeral Service Licensee    22. Name and Address of Feeling    23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,    23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,    23b. Malling Address (Street end Number or Rural Route Number, City or Town, State 2 (20c. Localian - City	17. Father's Name (Firs		)				18. Mothe	r's Name (First, N	tiddle, Ma			12575.01
Virginia Gale / Daughter   298 Canterbury Road   Bel Air, Maryland   21014	Stanis	slaw		Vieso	hskie		Mar	'y 5	Sowul		UT P	
20a. Harbod of Disposition  Will Burlai / 2   Cremetion   3   Denoval from State   20c. Localion - City or Town, State   20c. Localion - City or T				A		1						
Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   24a. Was an autopsy performed?   24b. Were autopsy in a validation of conditions contributing to death but not resulting in the underlying cause given in Part I.   24a. Was an autopsy performed?   24b. Were autopsy in a validation of conditions contributing to death but not resulting in death   2 and to perform a validation of conditions contributing to death but not resulting in death   2 and to perform a validation of conditions contributing to death but not resulting in death   2 and to perform a validation of conditions contributing to death but not resulting in the underlying cause given in Part I.   25b. Did tobacco use contribute to the cause of conditions contributing to death but not resulting in the underlying cause given in Part I.   25b. Did tobacco use contribute to the cause of conditions contributing to death but not resulting in the underlying cause given in Part I.   25b. Did tobacco use contribute to the cause of conditions contributing to death but not resulting in the underlying cause given in Part I.   25b. Did tobacco use contribute to the cause of conditions contributing to death but not resulting in the underlying cause given in Part I.   25c. Place of Death   25c			vaugn	20b. I	Place of Disp	osition (Neme of			-			
22. Name and Address of Fecility Leonard J. Ruck, Inc. Baltimore, Md. 21214  23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate finitive. Use only one cause on each line.  Immediate cause (Final interest or conditions, resulting in death)  Due to (or as a consequence of):  25b. Did tobacco use contribute to the cause of adaptive and the death of the contribution of th	W Burial 2 □C	remation 3		m State	cem <i>etery</i> , cr	emetory or other pi						
Leonard J. Ruck, Inc. Baltimore, Md. 21214				-								
23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate interest and the disease or near the mode of dying, such as cardiac or respiratory arrest,  Approximate interest and the death of the cause of each line.  Rent Failure  But (or as a consequence of):  Due to (or as a consequence of):  24a. Was an autopsy performed?  24a. Was an autopsy performed?  24b. Were autopsy in available prior to completion of cardidath?  1   Yes   2   No   3   Probably   4   0    25. Was case referred to medical examiner?  1   Yes   2   No   3   Probably   4   0    26. Place of Death (Check only one)  27. Manner of Death   1   Medical investigation   1   Yes   2   No    28b. Date of Injury   28b. Time of Injury   1   Yes   2   No   No	11111	16				Leonard 3	. Ruck	, Inc. E	Balti	more,	Md.	21214
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23b. Did tobacco use contribute to the cause of 1   Yes 2   No 3   Probably 4   Other completion of cate of death?	disease or condition resulting in death)	ıl	8.	Due to (	or as a cons	equenca of):					1	
Cause (Disease or Injury that Initiated events resulting in death) Last    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.   23b. Did tobacco use contribute to the cause of   1   Yes 2   No 3   Probably 4   24a. Was an autopsy performed?   24b. Were autopsy performed?   24b. Were autopsy performed?   1   Yes 2   No 3   Probably 4   24c. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   24c. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   24c. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   24c. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   24c. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   24c. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   24c. Was an autopsy performed?   1   Yes 2   No 2   Yes 2   No 2   Yes 3   Yes 3   Yes 4   Yes 5   Yes 4   Yes 4   Yes 5   Yes 5   Yes 6   Yes 6   Yes 6   Yes 7   Yes 7	Sequentially list conditi	ons,	b								1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobecco use contributs to the cause of 1   Yes 2   No 3   Probably 4   20   No 4	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.											
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25. Was case referred to medical examiner?    Yes   2   To   Hospital:   I   I   I   I   I   I   I   I   I								24a.	Was an	autopsy	24b. W	ere autopsy findings
25. Was case referred to medical examiner?									periorme	ed?	CC	empletion of cause
examiner?  1 Yes 2 No  Hospital: 1 Infination 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Offier (Specify) Hussing Home 5 Residence For Injury At North Hussing Hus									1 🗆 Yes	2 10 No	1	□Yes 2□No
1   Yes 2   No		o medical					-	of Death (Check	only one)	)		
2   Accident 3   Suicide 4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street end Number or Rurel Route Number of Rurel Route Nu	1 ☐ Yes 2 ☑ No		11			AND DOW	4 140					m) Huspice
3   Suicide 4   Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only one)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office Chy or Town, State)  28f. Location (Street end Number or Rurel Route Number Chy or Town, State)  29a. Certifier (Check only one)  28d. Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)	1 DNatural 5		(Mo	onth, Day Year)					Cribe now	rinjury occur	190	
29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signalure and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)	3 Suicide 6 Could not be						28f. Localion (Street end Number or Rurel Route Numbe				el Route Number,	
(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)	4   Homicide		Duil	ding, etc. (Speci	ry)			City	or rown,	Siate/		
	(Check only 2		niner: On the	basis of examina								
143725 6/14(00	29b. Signature and fitte	of certifier		- Fla					290			
	1/4	1=				D	4372	5		61	14(0	0
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMUUD 201-109 Back Rivar Necle Read Baltimers MD212	MICICIA	1HHW Nay, Year)		Registra Sign		ce - 10 ay	104616	2000	130	111000	10	

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State Registrar

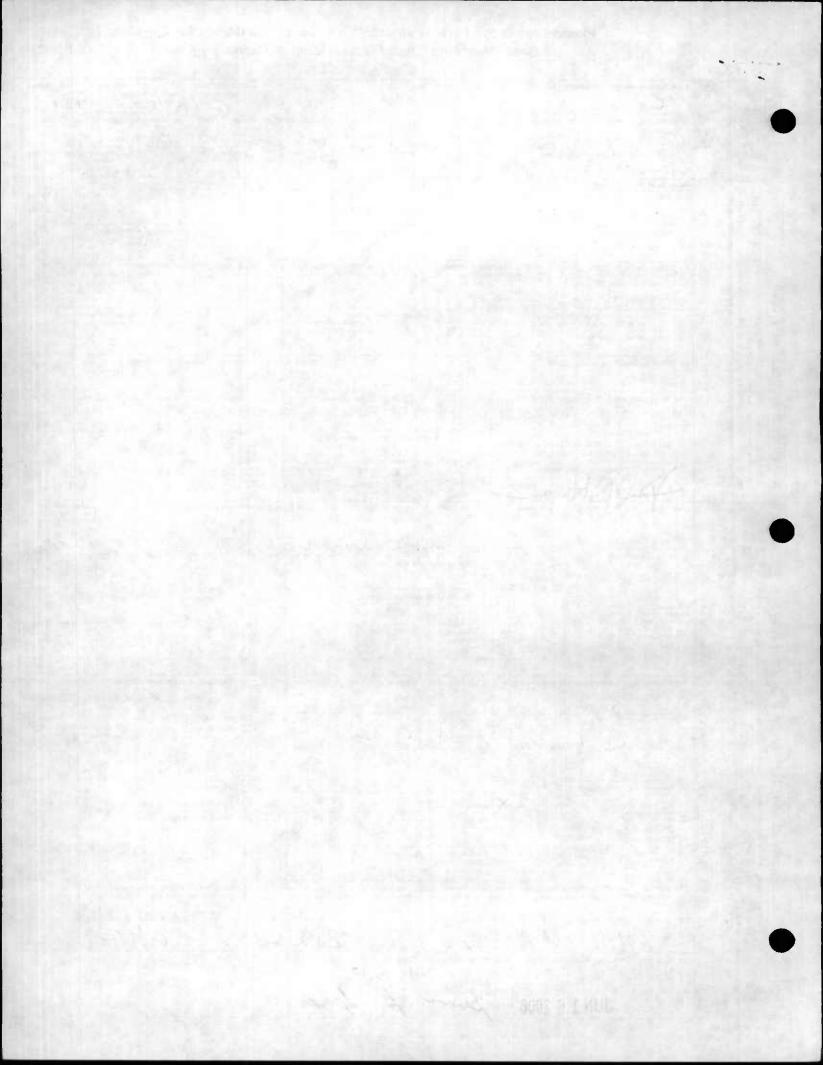


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dey Month **Physician** 521P Carmela Piergiak 00 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltmore 08 d Kospita 7. Age (In yrs. last birthday) Baltimara If Under 24 Hrs. MO University Maryland If Under 1 Year 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) **Funeral** 10 M 2 F Min. Months Days Hours 84 217-22-5691 Director 1915 MARYLAND Usual Residence of Decedent 10e. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 Yes 2 No GLEN BURNIE MARYLAND ANNE ARUNDEL Director 10a, Citizen of Whet Country? 10e. Street and Number 10f. Zip Code Harrie 23a or 21061 II.S.A. 413 GLENMONT AVENUE Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Dates: 14. Raca - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be Illed within 72 hours ahar next of Health and Mental Hygiene.
set if Item 72 is marked other then "natural", or he ury or other traumatic event, the Medical Examities ury or other traumatic event, the Medical Examities 1 ☐ Never Merried 2 ☐ Merried 21215-0020 1 ☐ Yes 2 No Specify: WHITE Specify: Ą 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Saftimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 88 CORRIALE FILIPPINA SOLE CARMELO 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stele, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 413 GLENMONT AVENUE, GLEN BURNIE, MD. 21061 AMELIA HOBBS (DAUGHTER) 20b. Piace of Disposition (Neme of 20c. Location - City or Town, State Date 20e. Method of Disposition cemetery, cremetory or other place) GLEN HAVEN MEMORIAL PARK 2000 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If GLEN BURNIE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., ral Sarvide Licenses 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Party. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. **Physician** /Medical Myelogenous Leukemia Immediate Cause (Finel diaeese or condition resulting in death) Examiner Due to (or es a consequence of) Examine The law requires that the death certificate be executed use as the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco was contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown of Vitai Records, g 24a. Was an autopsy performed? 24b. Were autopsy findings aveilable prior to edical Certification: To Be Completed completion of cause of deeth? page 2 certificate has 20 No 1 ☐ Yes 2 ☐ No Physician: ours after death.

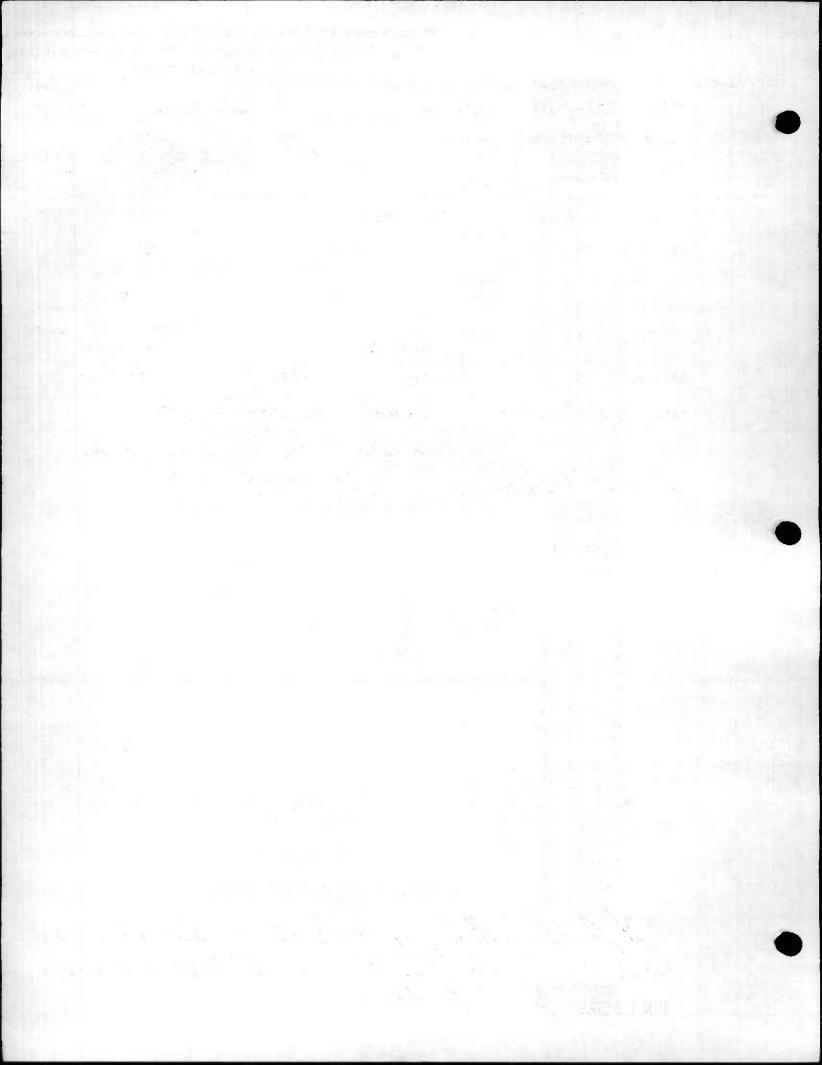
The present of the secution of the secution of the funeral director. 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 28e. Date of Injury (Month, Dey Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred or Attending Division atural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner steted. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier MA 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) & Greene 5+ Bultmore Kus 22 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State JUN16 2000 Registrar



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1			Pickersgill Reti	rement	Communi	ty		Tot	vson		Ba1	timore	
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ar	sho and A	-	19e. Informent's Neme/Reletionship	Type, Print)		19b. Me	iling Addrass (Stre	et end Num	ber or Rur	al Routa Numbe	er, City or Town,	Stete, Zip Code	)
Σ	alth 27 i		Mrs. Judy M. Gree	er/niec	e	511	Locksley	Rd.	Tows	on, Md.	21204		3
ore	of He		20e. Mathod of Disposition	30	20b.	Plece of Dis	position (Name of ramatory or other p	olace)		Dete	20c. Location -	City or Town, S	itate
Ĕ	Pag int: H		1 ☐ Burial 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		State		Valley Me		1 6	5/19/00	Timoni	um, Md.	
Baltimore, Maryland 21215-0020	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any follury or other traumatic event, if a Modical Experience must be notified as ance.		21. Signature of Funeral Sarvice bice	Treat			22. Nama and Add	dress of Feci	ility				
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	1		30. Name and eddress of person who	complated cau	sa of death (Ite	1 23a) (Type	e, Print)	lal-	. /	12	00 "	201 >	02.41
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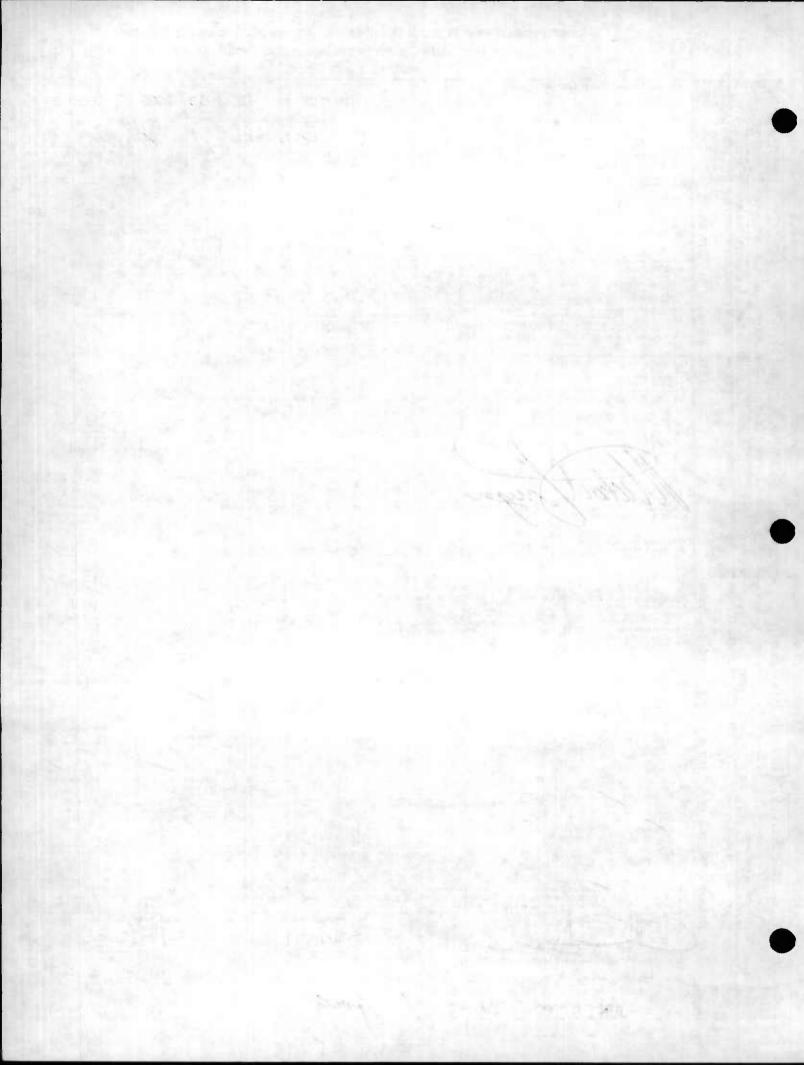


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State of Maryland / Department of Health and Mental Hygiene 19147

Usual Residence of Decedent  10a. State 10b. County  MD N/A  10e. Street and Number  6511 HOPETON AVI  11. Merital Status  1 Never Merried 2 Married  3 Midowed 4 Divorced  (Specify only highest grace)  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)  SAMUEL  19a. Informant's Name/Relationship (7)  LARRY PRINCE / Secondary (0-12)  20a. Method of Disposition  18 Burial Commandian Secondary (0-12)  19a. Informant's Name/Relationship (7)  LARRY PRINCE / Secondary (0-12)  20a. Method of Disposition  18 Burial Commandian Secondary (0-12)  20a. Method of Disposition  19 Burial Commandian Secondary (0-12)  21. Signal of Longration 3 Divorced  22. Secondary (0-12)  23a. Part. Enter the disease or complementary (0-12)  24 Signal of Longration 3 Divorced  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?	ENUE  12. Was Decedarmed For 1   Yes, Give Year or Date of College (1-1)  JACOB	NURSING 7. Age (In yrs. Ia 91 10c. City, dent Ever in U,S cces? 2 M No	Town or Loc BAL	TIMOR	1 Yeer Deys		IMOR	2. Date of Death JUNE 13 coation of Death E  8. Dete of Birth (Month, Day, AUG • 27	4c. County BAI	TIMO	place (Stete or Forentry)
Saminer   4a Facility Name (If not institution, give JEWISH CONVALES)   JEWISH CONVALES   15   16   16   16   16   16   16   16	FINUE  12. Was Deceded Armed For 1   Yes , Give Year or Da adducation and completed)  College (1-1)  JACOB	NURSING 7. Age (In yrs. Ia 91 10c. City, dent Ever in U,S cces? 2 M No	Town or Loc BAL	Months cation TIMOF	1 Yeer Deys	BALT:	IMOR	E 8. Dete of Birth (Month, Day,	BAI Year)	TIMO	place (Stete or Forentry)
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10a. State   10b. County   N/A   10e. Street and Number   6511 HOPETON AVI   11. Merital Status   1   Never Merried 2   Married   3   Widowed 4   Divorced   15. Decedent's Edit (Specify only highest grace   16. December	12. Was Decedarmed For 1 Test If Yes If Yes, Give Year or Da ducation ade completed)  College (1-	dent Ever in U.S. ces? 2 X No	BAL 13. V	TIMOR							MD
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17. Father's Name (First, Middle, Last)  SAMUEL  19a. Informant's Name/Relationship (T.  LARRY PRINCE / S.  20a. Method of Disposition  Burial Committee (T. S.)  21. Signal of Linear Survice (T. S.)  21. Signal of Linear Survice (T. S.)  Immediate Cause (Final disease or companion of the committee (T. S.)  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Part II. Other significant conditions conditions or companion of the cause (T. S.)  Part II. Other significant conditions condition	JACOB		16a. Deced (Give	kind of wor	k done	during most	t of work	ing	16b. Kind of Bu	siness/In	dustry
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25. Was case referred to medical examiner?  1						, 44		1 🗆 Ye		of	ompletion of cause death?
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3 Suicide 6 Could not be determined	28a. Date o (Month		ER/Outpatien 28b. Time of Injury	-	8c. Inju	her: 4X Nu	ursing Ho	ome 5 ☐ Reside 28d. Describe ho	enca 6 □Oth		'ty)
	Zoe. Placa	of Injury - At horng, etc. (Specify)	me, farm, stre	eel, factory	r, office			28f. Location (St City or Town		er or Rur	ral Route Number,
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200 Signature operfile of certifie			1.34	290	Licens	se number		2	29d. Date signe	d (Month,	Dey, Year)
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**ORIGINAL** 



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9118 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month CHARLES PAYNE 2000 June 6, 7:00 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Eldercare-Heritage Center Baltimore If Under 1 Year If Under 24 Hrs. Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1⊠M 2□ F Yrs. Oct, 20, 1922 217-18-5902 unk Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 7232 German Hill Rod Funeral 21212 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No H Yes, Give Vear or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7232 German Hill Rd Baltimore, MD 21212 Heritage Center-Genesis Eldercare 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in state 21. Signature of Funeral Service Licens Ronald S 22. Name and Address of Facility Wade Director State Anatomy Board 655 W. Baltimore Street 11 alle Baltimore, MD 21201 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death NEW ONSET SEIZURE DISORDER Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): NSULIM DEPENDANT DIABETES MELLITUS Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initioted events resulting in death) Last DEMENTIA Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Whitnown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place gl/Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1\DNatural 2 Accident 5 Pending 1 Yes 2 No investigation 281. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed use as the burial-trans P.O. Box 68760. page 2 should be de Division of Vital Records. certificate or Attending Physician: funeral director, this After within 24 hours after death. To the Funeral Director: A filled in by

Hospital

9

**Physician** 

**Funeral** 

Director

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"natural", or items ?

pemit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental hygiene. Important: If Itam 27 Ia marked other than "natural", or ther any Injury or other traumatic event, the Medical Exeminar

Physician

/Medical Examiner

Physician/Medical Examiner

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Be

Medical Certification: To

Baltimore, Maryland 21215-0020

death v

Director

/Medical

6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of cartifier W) welle

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willen 2 Marles

lare Battinere MD 2/222

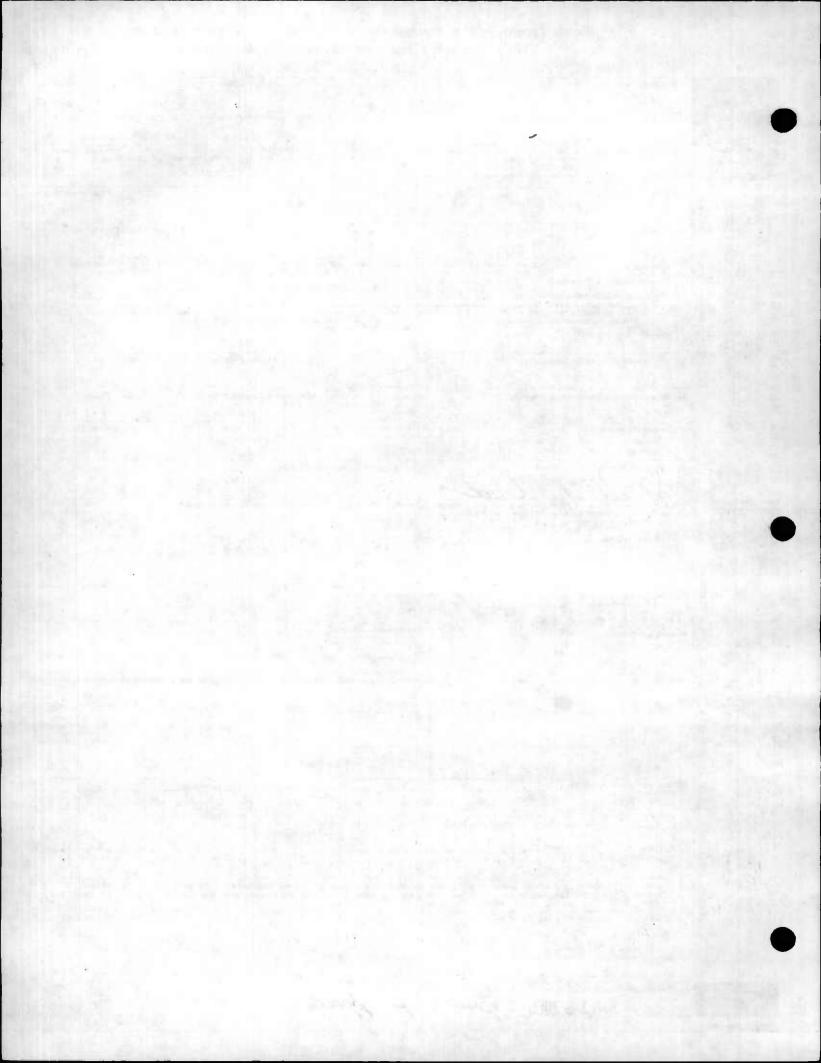
31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 1 6 2000

State Registrar

completely



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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aminer	4a Facility Name	(If not institution, give					or Location of Deat	th 4c. County	of Death	
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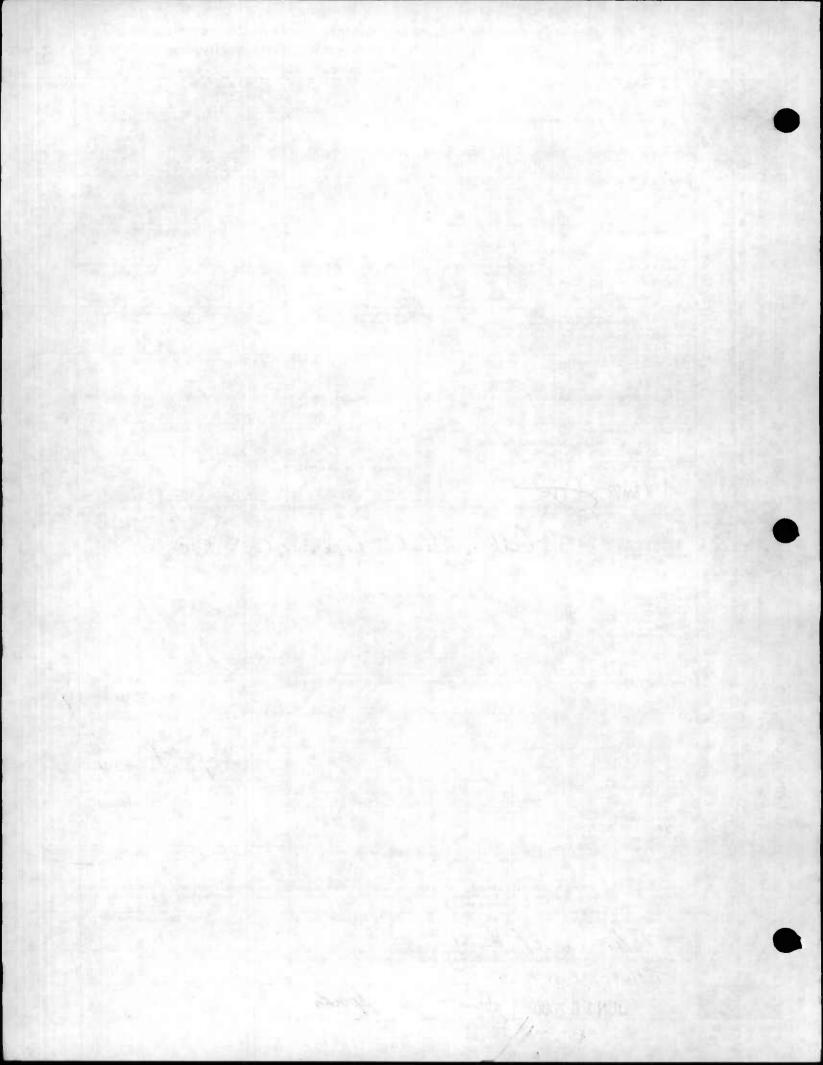
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State of Maryland / Department of Health and Mental Hygiene

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eral ctor	5. Sociel Security N 219-40-	5595	Sex 100 M 20 F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Yeer Months Deys	If Under 24 Hr Hours Min		3-41	9. Birthp	NC
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atio	1 Natural 2 Accident	5 Pending investigation	on	,,	i i ijui y		Yes 2 □ No	I N ENN			
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	30. Name and address	ress of person who	completed cause	ol deeth (II)			treet P	Baltimore,	Marvi	and 2	1201



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of the Month Day **Physician** Norman Clement. Smith June 12, 2000 10:50 am /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1130 Greenway Road Cockeysville Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 15 M 2□ F Months Devs 89 Director 215-09-2963 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location show 10d. Inside City Limits Nem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1130 Greenway Road 21030 USA 12. Wes Decedent Ever In U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. tem 27 is marked other than "natural", or ite 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merried 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) 12 n/a Bricklayer General Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Vincent John Smith Sarah Ann Scott 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is Elizabeth Ann Quinn/Daughter 813 Ivydale Avenue, Reisterstown, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stete injury or 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Gardens 6/16/00 Finksburg, Maryland 22. Neme end Address of Facility Bryan W. Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. 1 complications that sused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, Physician /Medical Immediate Cause (F disease or condition resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pug Due to (or es e consequence of): burial-tran Records, P.O. Box 68760. physician is the burial Physician/Medicai Due to (or as a consequence of): attending I signed by the al Part II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Type 2 No 3 Probably 4 Donknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2 No 2 1 | Inpatient 2 | ER/Outpetient 3 | DOA this 27. Mannet of Death 28e. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Naturel death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attency within 24 hours after death To the Funeral Directors. filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 C Homicide edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and eddress Arson who completed cause of dea

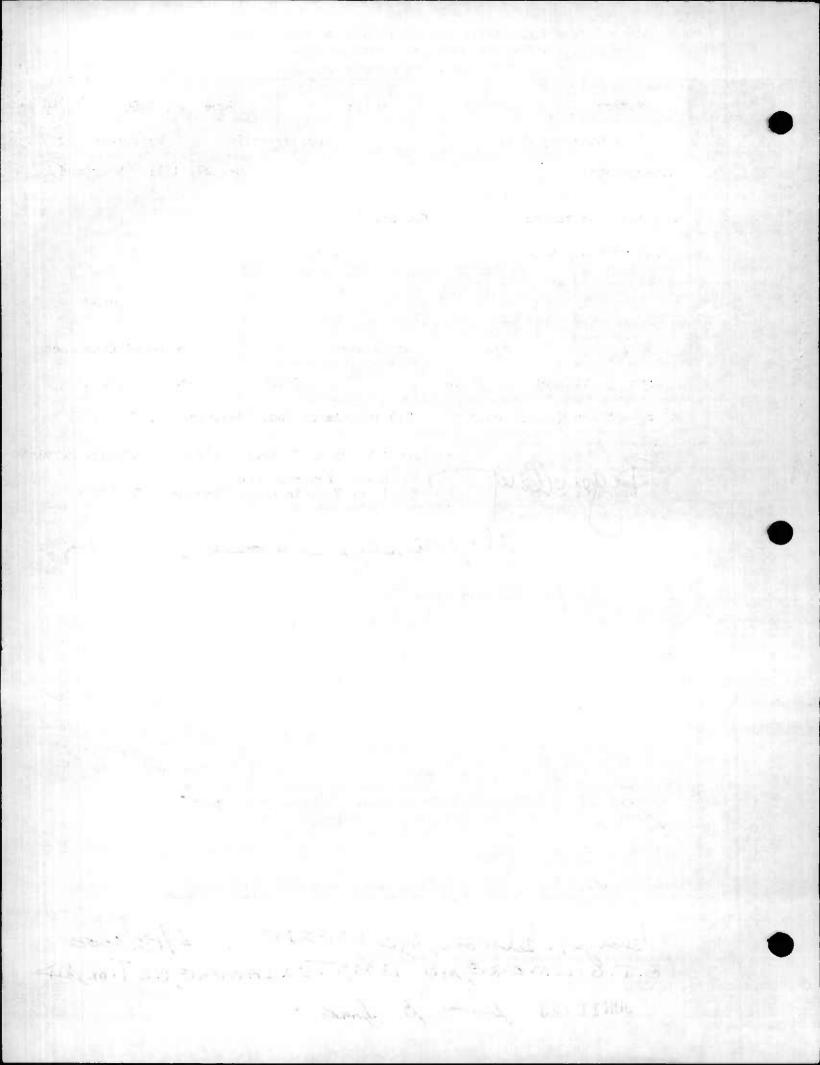
31. Dete filed (Month, Day, Year)

irson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

= MD

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### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year RHEA 15th 2000 SCHROEDER 5-15 AM J JUNE 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 1 DM 20 F Yrs. 220-12-6239 5/12/25 MARYLAND Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD BALTIMORE COCKEYSVILLE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10535 YORK ROAD APT. 112 21030 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status 1 Navar Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) College (1-4or 5+) SECRETARY MD ANATOMY BOARD 12TH GRADE 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) AUGUST STITLEY ALMA UNAVAILABLE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) KENNETH PAUL SCHROEDER HUSBAND 10535 YORK ROAD APT. 112 COCKEYSVILLE, MD 21030 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from Stata 4 □ Donation / 5 □ Othar (Specify) BALTIMORE NATIONAL CEM. 6/19/2000 BALTIMORE, MD 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. the 01 8521 LOCH RAVEN BLVD. TOWSON 21286 MD Lenter the disease, or comp., allons the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only 9 is cause of each line. Approximata Interval Between Onset and Death Immediata Causa (Final diseasa or condition rasulting In death) a LILOSEPSIS Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Causa (Disaasa or injury Dua to (or as a consequence of): that initiated events resulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 € No 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Director

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P.O. 1

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Division of Vital

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 Funeral Director: After this certifica

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Physician/Medical Examiner ģ Be Completed

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29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. License number

MO aral 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

29d. Data signed (Month, Day, Year) JUNE 15th 13457 2000 5601 LOCATRAVEN BUD

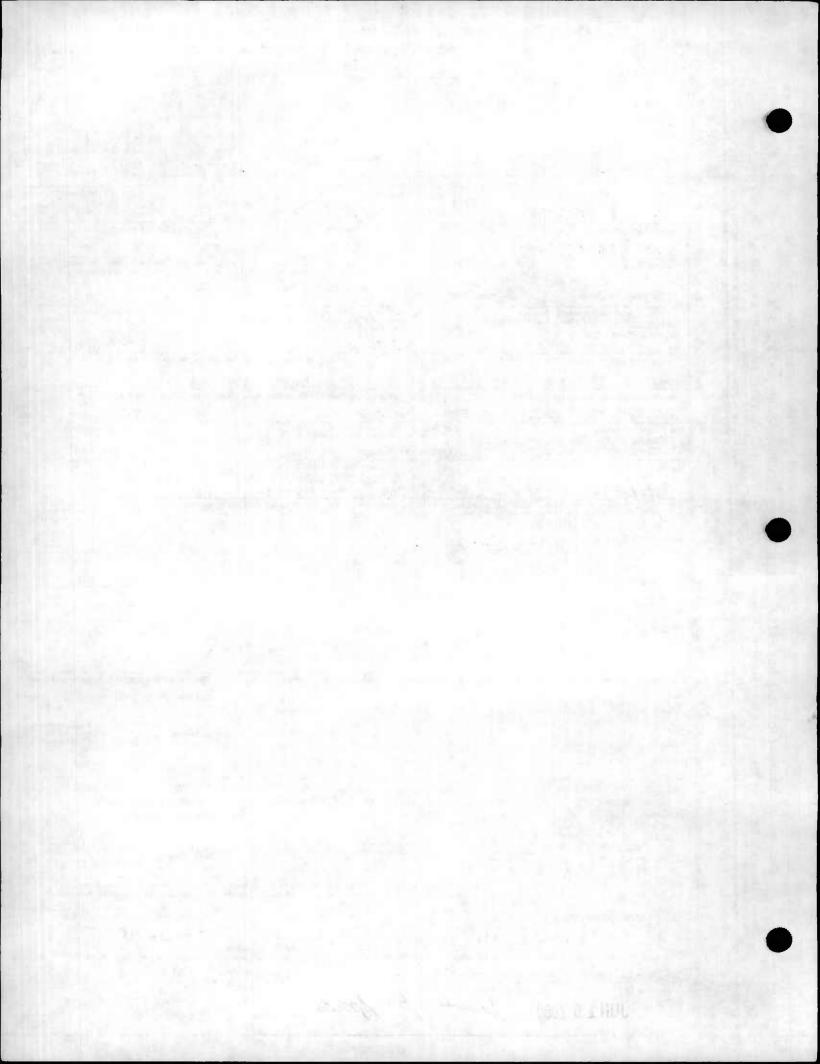
To GOOD SAMARITAN HOSPITAL BALTIMORENIO 21239 ROSEMANE RAMPERSAD-MAKAS

31. Deta filed (Month, Day, Year)

JUN 1 6 2000

32. Registrar's Signatura

State Registrar



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

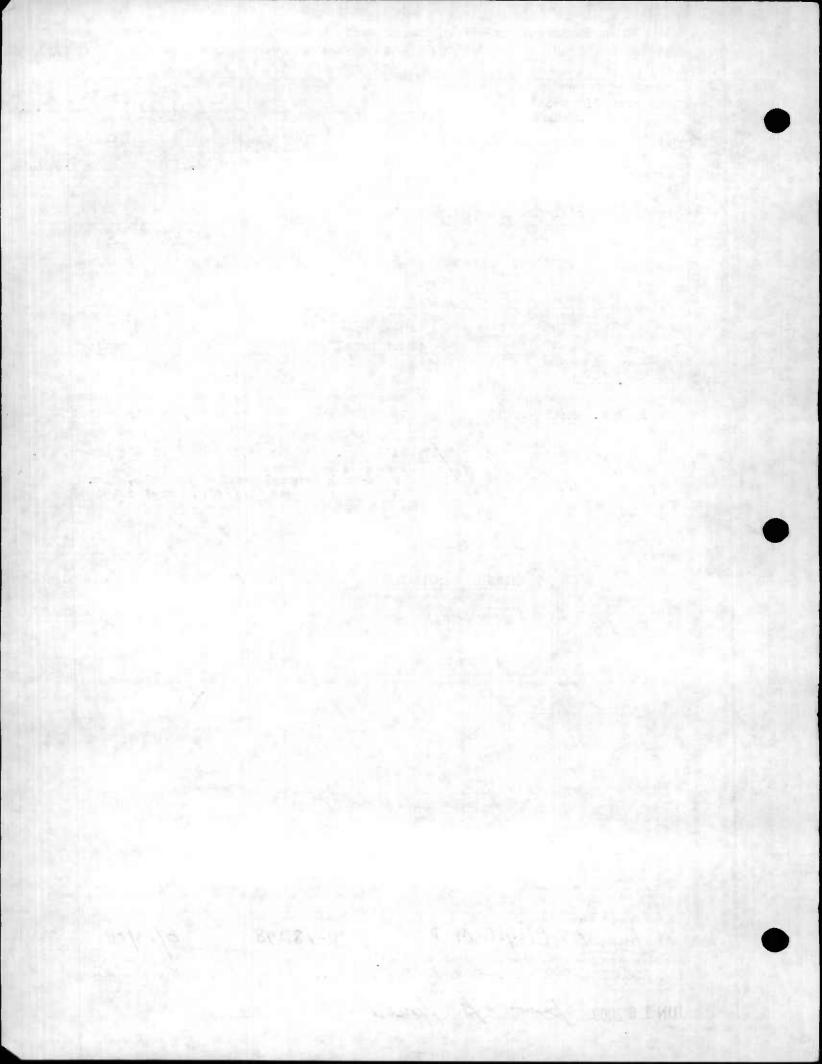
State of Maryland / Department of Health and Mental Hygiene

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	28 the	Director	10e. Street and Numb	er					10f. Zip Code				10g. Citizen of	What Coun	try?
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	ter dea	5	1 Never Married	2/7 Marrie	Armed	Forces?			If Yes, specify Cub	an, Mexical	n, Puerto	Rican, etc.)	Bla	ck, White,	etc.
Ž	f, or	by	3 ☐ Widowed 4 [		If Yes,	Give Detes:	1947-		1 ☐ Yes 2 🖾 No	Specify:			Specif	y: Wh	ite
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٥	death of for	Sicial	Part II. Other significa	nt condition	s contributing to	death bu	t not resulting	in the u	inderlying cause gir	ven in Part	1.	23b. Dld	tobacco use co	ontribute to	the cause of death?
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	1		DR. AUGUST	IN CHY	U, M.D.	96	00 NOR	TH P	OINT RD.	, FOR	T HO	WARD, M	ARYLAND	2105	2
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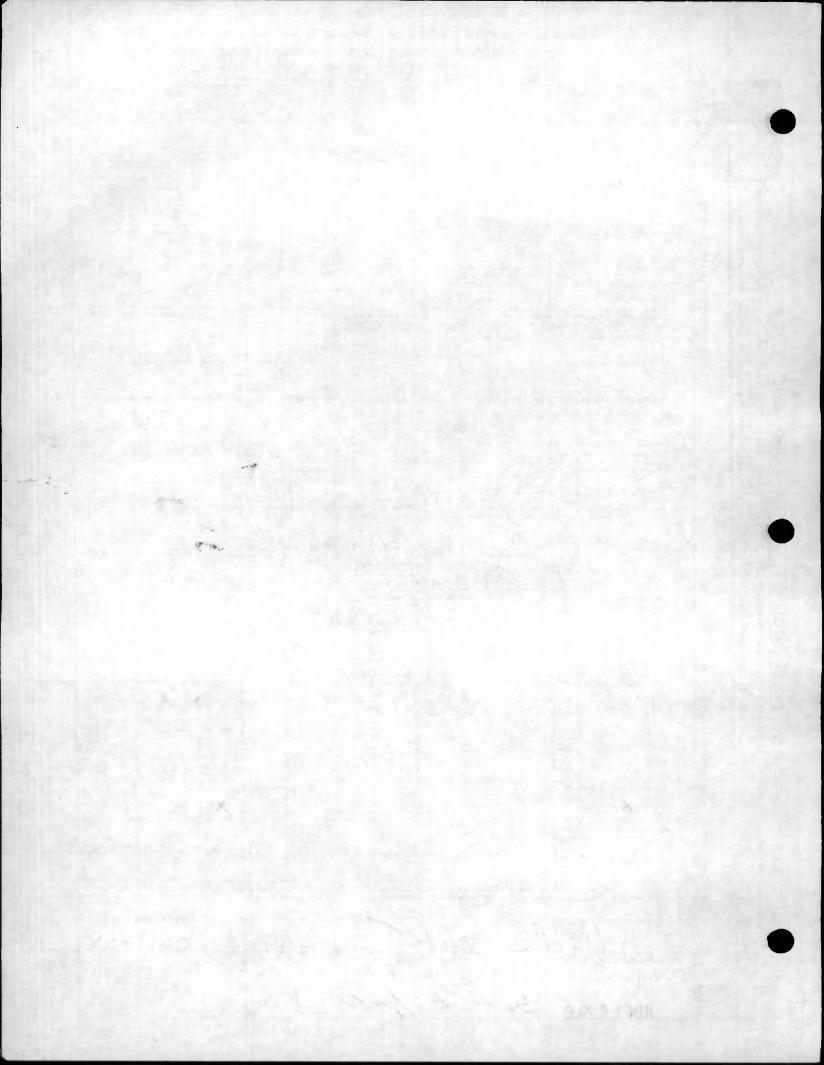
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Defe of Death 3. Time of Death Day Year **Physician** Albert Stol JUNE 1:20 PM 13,2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Center Baltimore City Bayview Hopkins Johns Medical If Under 1 Year | If Under 24 Hrs. 8. Def of Birth (Month, Dey, Year) Aug. 11, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 74 Yrs. Birthplece (State or Foreign Country) **Funeral** XXM 2DF 218-18-7653 1925 Maryland Director Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Director Dundalk 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 3204 North Point Road 21222 United States death y Funeral 12. Was Decedenf Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yès, Give Yaar or Detes: WW Was Decedenl of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marifal Status tiled within 72 hours after 1 ☐ Never Married 2 ☐ Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced WW II Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be tiled within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other traumatic event. the Mean Injury or other traumatic event. Elementery/Secondary (0-12) College (1-4or 5+) Payroll Clerk 12 years Stee1 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be John Stoll Mattie Gurdison 2 19e. Informent'a Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth F. Stoll (Wife) 3204 North Point Road Dundalk, Maryland 21222 20b. Placa of Disposition (Name of 20c. Location - City or Town, Steta 20a. Method of Disposition Date cematery, cremetory or other piece) 1 ♥Buriel 2 □ Cremation 3 □ Removal from State Gardens of Faith 6/17/2000 Rossville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funarel Sarvice Licensee 22. Name and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue 7. Dauboch Dundalk, Maryland 21222 23e. Part1. Enter the disease, or complications to shock, or heart feilure. List only one cause lat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final Sepsis disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner Dreuminia g physician and as the burial-transit Sequentielly list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or tnjury that initiated events resulting in death) Last Due to (or es a consequenca of): Box 68760 Physician/Medical Due to (or as e consequenca of): 987 ò PO been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown of Vital Records. þ 24b. Were autopsy tindings available prior to completion of causa of death? Completed 24e. Was an autopsy performed? certificate has 1 ☐ Yea 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 Hopatient 2 □ ER/Outpatienf 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□Yes 25 No 10 27. Menner of Death 1. Selatural 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Attending 5 Pending death. Investigation 1 Yes 2 No 2 Accident Director: / 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Straet end Number or Rural Route Number, City or Town, Stete) 28e. Piace of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by or A after 4 Homicide To the Hospital ... within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner steled. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and fitte of certifier June 13, 2000 INTERN ND M 30. Neme end address of person who completed causa of death (Item 23a) (Type, Print) Chiana Chter, Baltimore, MD Hopkins Medica 1 Lillian Johns Bayvia JUN 1 6 2000 32 Registrar Gigneture State Registrar

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State of Maryland / Department of Health and Mental Hygiene

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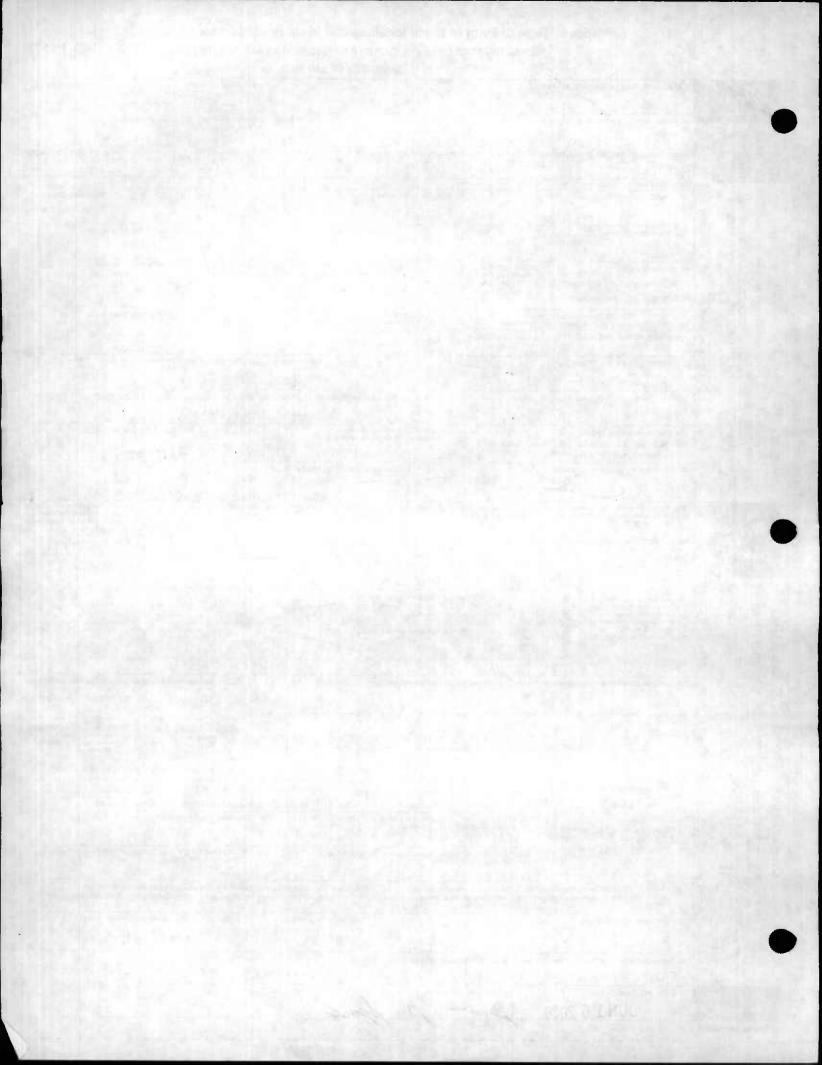
State of Maryland / Department of Health and Mental Hygiene

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edical Certification: To Be Completed by Physician/Medical Examiner	Sequentia if any, lea ceuse. E Cause (D that initial resulting in the ceuse of the	ally list condition in death)  ally list conding to immuner under the condition of the cond	nditions, mediate rying injury .ast	g pation not be ined g Physician Examiner:	pital: 1 28a. Date (Mor	During During During During During During During Death but in the control of Injury of the Control of Injury of the Control of Injury of the Control of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of the Control of Injury of	e to (or as a  POTEN  e to (or as a  rot resulting if  2 ER/Or  ear)  28b.  At home, for  Specify)  They knowledge amination and	Consequence conseq	uence of):  uence of):  uence of):  uence of):  uence of):  dertying cau  t 3 DOA  A 286  M eet, factory, or occurred at restigation, in	Oth C. Injury Office the time in my o	26. Place er: 4 Nor yat k? Yes 2 Inne, date ar pinlon, dea e number 3 4 3 6	e of Deathursing Ho	23b. Dkc 1 24a. Wa per 1 Check only me 5 Re: 28d. Describe 28f. Location City or T.	d tobacco  Yee 2  s an auto formed?  Yes 2  one) sidence how inju  (Street e.own, State cause(s, date an  29d. Da	ppsy  6 Other or occurrence of the property occurrence occurrence occurrence of the property occurrence occur	24b. We ave cor of control of con	Onset and De  / OAT  OAT  OAT  OAT  OAT  OAT  OAT  OAT



00-3293-031 B.K.S SANDRA M S			ase Type or State of	of Maryland	Depa	rtmen	t of I	Health :	and M	•	_	ible.	19158
AMEND TTE Physician /Medical Examiner	CHIMANSKI MS: #23 PART I, 27 PER MEO G784 Certificate of 1. Decedent's Name (First, Middle, Last) Sandra Marie Schimanski						e of	Death		2. Date of Dec Month JUNE	Day	Year	3. Time of Death 1945 PM
	4a Facility Name (If not institution, give street and number) 12522 GREAT PARK CIRCLE							4b. City, Town, or Location of Deeth GERMANTOWN			4c. County of Deeth MONTGOMERY.		
Funeral Director	5. Sociel Security 339-74-65	Number 91	6. Sex 1  M 2  F	7. Age (In yrs. lest)	birthdey) Yrs.	If Under Months	1 Yeer Days		24 Hrs. Min.	8. Date of Birt (Month, De December	v. Year)	Cou	plece (Stete or Foreign ntry)
with the Maryland or 28a-f show be notified at Director	Usual Residence of Decedent												
	10a. Stete MD					10c. City, Town or Location  Cermantown							10d. Inside City Limits  YSS Yes 2 □ No
	10s. Street and Number 12522 Great Park Circle					10f. Zip Code 20876					10g. Citizen of What Country? United States		

is and Mental Hygiene.
Is merked other than "natural", or flems 234
is merked other than "natural", or flems 234 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 Yes 2 No lif Yes, Give Year or Dates: Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Important: If them 27 is marked other than "natural", or the 1 ☐ Never Married 2 N Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2KKNo Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Barbara Tichy Andrew M. Birsa, Sr. 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Scott A. Schimenski / Husband 12522 Great Park Circle, Germantown Maryland 20876 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐Removel from Stete ò Resurrection Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Servica Licensee Victor P. Doda, Jr 22. Name end Address of Facility Charles L. Stevens Funeral Home, Inc.

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

1501 East Fort Avenue, Baltimore Maryland

Examiner

Physician/Medicai

þ

Completed

86

Medical Certification: To

**Physician** 

/Medical

Examiner

signed by the attending physician and defected for use as the burial-transit

cate has been significant category.

certificate has

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Physician:

The law requires that the deeth certificate be executed

Division of Vitai Records, P.O. Box 68760.

CARDIAC ARRHYTHMIA Immediate Cause (Final diseese or condition resulting in deeth)

Approximate Interval Between Onset and Deeth

14. Race - American Indien, Black, White, etc.

Department Store

Romeoville, IL

Specify.

White

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

DISSECTION OF CORONARY ARTERY Due to (or es a consequenca of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No

24a. Wes an sutopsy performed?

24b. Were eutopsy findings available prior to completion of cause of death?

12 Xes 2□ No

19€Yes 2 No

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE

25. Wes case referred to medical exeminer? 1X Yes 2 No 27. Menner of Deeth 1 X Natural 2 Accident

5 Pending investigation 6 Could not be determined

28a. Dete of Injury (Month, Day Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end manner stated. 29c. License number

29b. Signature end title of certified

O.C.M.E

29d. Dete signed (Month, Dey, Year) JUNE 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar



THE THE THE THE STATE of STATES

# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

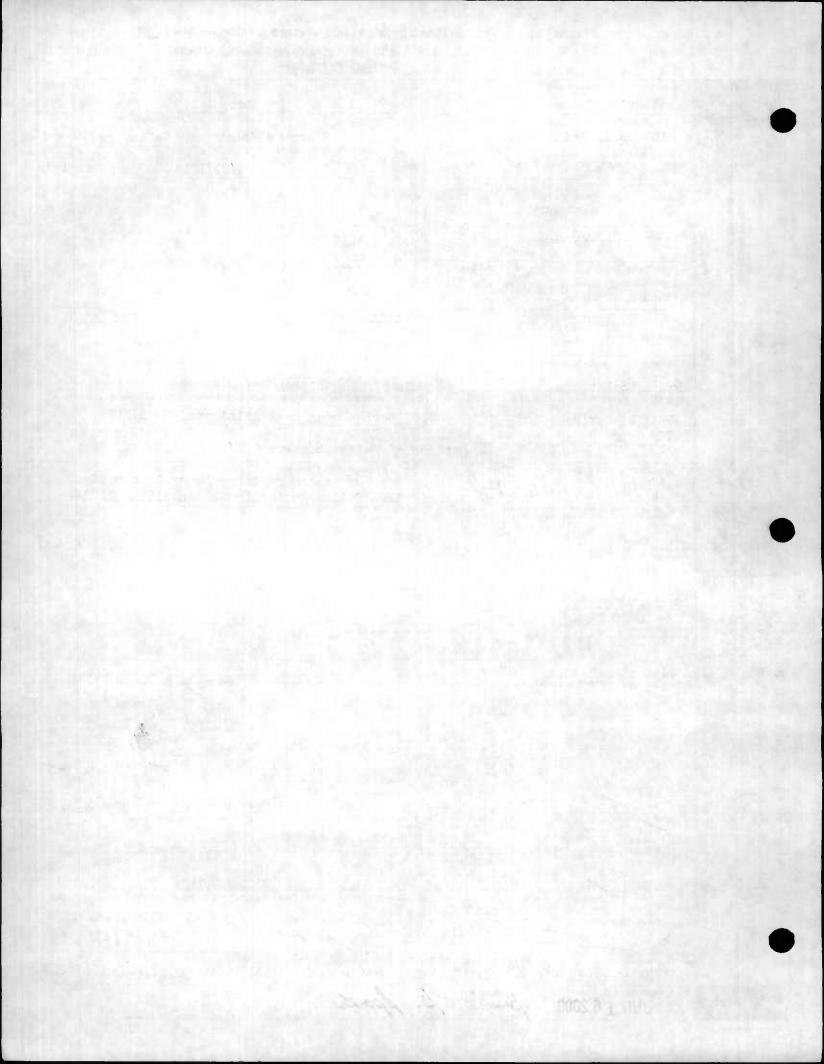
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Katherine J. Say 2000 2:45 pm June /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 9107 North Point RD Sparrows Point Baltimore If Under 1 Year If Under 24 Hrs. 8. Dele of Birth (Month, Dey, Year, 08/21/1913 9. Birthplece (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In vrs. lest birthdev) **Funeral** Months 232-03-6040 Director Usual Residence of Decedent the Maryland 10a. Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD Baltimore Dunda1k 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 205 Patapsco Avenue 101. Zip Code 21222 10g. Citizen of What Country? death with USA 12. Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Maritel Status Bleck, While, alc. Pages 1 end 2 should be filed within 72 hours after nent of Health end Mental Hygiene. int: If item 27 is marked other than "natural; or ite Yes 2 No 1 ☐ Never Merried 2 ☐ Married 21215-0020 1□ Yes No Specify. Specify: White Be Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home Maryland 17. Felher's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Rose Lopez Missena John Nicolette 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 9107 North Point Road Baltimore, MD 21219 John L. Davis Son other Baltimore, 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20a. Method of Disposition Deta 20c. Location - City or Town, State Depentment of Important: If it any injury or or phose. 1 Burial 2 □ Cremetion 3 □ Removel trom State 06/13 Baltimore. MD Gardens of Faith Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licent 22. Name end Address of Fecility Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring Road, Dundalk MD 21222

23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest,

Approx Approximata Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical 8 mo Lema Cancer **Examiner** Due to (or es e consequence ot) Physician/Medical Examiner The law requires that the deeth certificate be executed use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence ot) attending physician Due to (or as e consequenca ot): P.O. Pert II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 3 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, by 24b. Were autopsy tindings available prior to completion of cause of deeth? page 2 should Completed 24a. Was an autopsy After this certificate has 1□ Yes 2 No 1 Yes 2 No I or Attending Physician: after deeth. Director: After this certification by the funeral director, Be 25. Wes case refarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Sother (Specify) Son's Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No edicai Certification: To 27. Manner of Death 28c. Injury el Work? 28d. Dascribe how injury occurred Division 1 Maturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28a. Placa of Injury - At home, term, street, fectory, office building, etc. (Specify) 28t. Location (Street and Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29c. License number 29d. Dale signed (Month, Day, Year) 29b. Signeture end title of certities m.D. DA5390 6/15/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYO MEN (M. O-) 6830 HOSPITAL OR # 206, BALTEMORE, MD 21237 31. Data filed (Month, Day, Year) 32. Registrar's Signatu JUN 1 6 2000 Registrar

PE



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Harriet Shebardson 2000 Mai /Medical 4a. Facility Name (If not institution, give street and number n of Death 4b. City, Town, or Location 4c. County of Death Examiner Mitchellville Prince Ebiscoba 5. Social Security Number George's Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex If Under 24 Hrs. **Funeral** Months 1 □ M 2 🗸 F 950 92 Vrs Director 042-12-95 Usual Residence of Decedent 01-23 MASS the Maryland 10a State 10b. County 10c. City, Town or Location 10d, inside City Limits an "natural", or Items 23a or 28a-f sh Medical Examiner must be notified MD Prince Georges Director Mitchellville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? death with 10450 Lottsford Rd 20721 #2-55L USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filled within 72 hours efferned of Health and Mental Hygiene.
Int. If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married . 04 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: ρ Specify: white 3 □ Widowed 4 ☑ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk unk 17. Falher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked r traumatic e Kimball Bessie C. Seavey 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If Item 27 is any injury or other trau Katherine Swift/friend unk 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation\_5 ☐ Other (Specify) 21. Signature of Europeal Service Scientific Wade, Director <sup>22</sup> Name and Address of Facility State Anatomy Board 655 W. Baltimore Street nou Baltimore, MD 21201 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart feilure. List only one cause on each line. Approximate Interval Between Onsel and Death Phis iciai Myocerdal Inforder /Medic .l Immediate Ceuse (Final disease or condition resulting in death) miner Due to (or as a consequence of): The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate ceuse. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last buriel-tran Due to (or as a consequence of) Records, P.O. Box 68760. ed by the attending physician deteched for use as the burie Physician/Medical as the Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown 10cm eru DUICOSC þ is certificate has been signe director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Was an autopsy performed? 1 Yes 2 No Division of Vital 1 ☐ Yes 2 ☐ No al or Attending Physician: The safter death.

I Director: After this certificate of in by the funeral director, pa Be 25. Was cese referred to medicet examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of injury (Month, Day Yeer) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Diracompletely filled in b 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) and mannar as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02507 30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print) You Executive Mice Landon Mo om inflmovalg 10 Don 1-1. 31. Date filed (Month, Day, Year)
JUN 1 6 2000 32. Registrar's Signeture book State Registrar

Harrist K. Staberdoon May 17 600 9 25 pm Colleagton Episcopal " + Hitchellulle Prince george" 042-12-950 " 94 0123-08

UNI 6 20°

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#28A PER MD. G784 6-16-2000 JAB 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day 2000 **Physician** 9 1:01 p.m. George Michael Tarburton, Sr. June /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore If Under 24 Hrs. 7. Age (In yrs. last birthdey) If Under 1 Year Months Deys Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) **Funeral** Deys Hours 1♥M 2□F 64 212-32-7295 Yrs. Dec. 26, 1935 Maryland Director Usuet Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits the Maryla 1 Yes 2 No Baltimore the Medical Examiner must be notified Maryland Baltimore Director 230-7 10f Zin Code 10g. Citizen of Whel Country? 10e. Street and Number herne 23s or United States 21224 7501 Carson Avenue Funeral Reca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus filed within 72 hours after 1 ☐ Never Merried 2 ☑ Married Yes 2 No f Yes, Give Specify: White 21215-0020 8 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) G. M. Assembly Line Manufacturing 7 years Baltimore, Maryland 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Mental Pages 1 and 2 should be Frances Nagengast Emerson Tarburton and in 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) riment of Health a riant: If Item 27 is Baltimore, Maryland 21224 7501 Carson Avenue Beatrice M. Tarburton (Wife) 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete Dete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 6/13/2000 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service Licensee 22. Name and Address of Facility Buda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between Onset and Deeth Do not enter the mode of dying, such as cardiec or respiretory arrest, 23a. Pert1. Enter the diseese, or complications that caused the shock, or heart failure. List only one cause on each line. Physician /Muu cal Immediate Cause (Finel disease or condition resulting in deeth) Lxamine Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last bunal-tran Due to (or es e consequenca of) pue Box 68760, attending physicier Physician/Medical the Due to (or es a consequenca of): 88 950 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, ð 24a. Wes an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? Completed certificate hes 1 Yes 2 No 1 Yes 2 No of Vital Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 □ EN/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of injury 28c. Injury at Work? 28d. Describe how Injury occurred After t Attending Division 1 Netural 5 Pending investigation I or Attending after death. I Director: Af 6-9-00 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piace, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of 6960 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 1576 Merritt Blud. Baltimore mozizzz

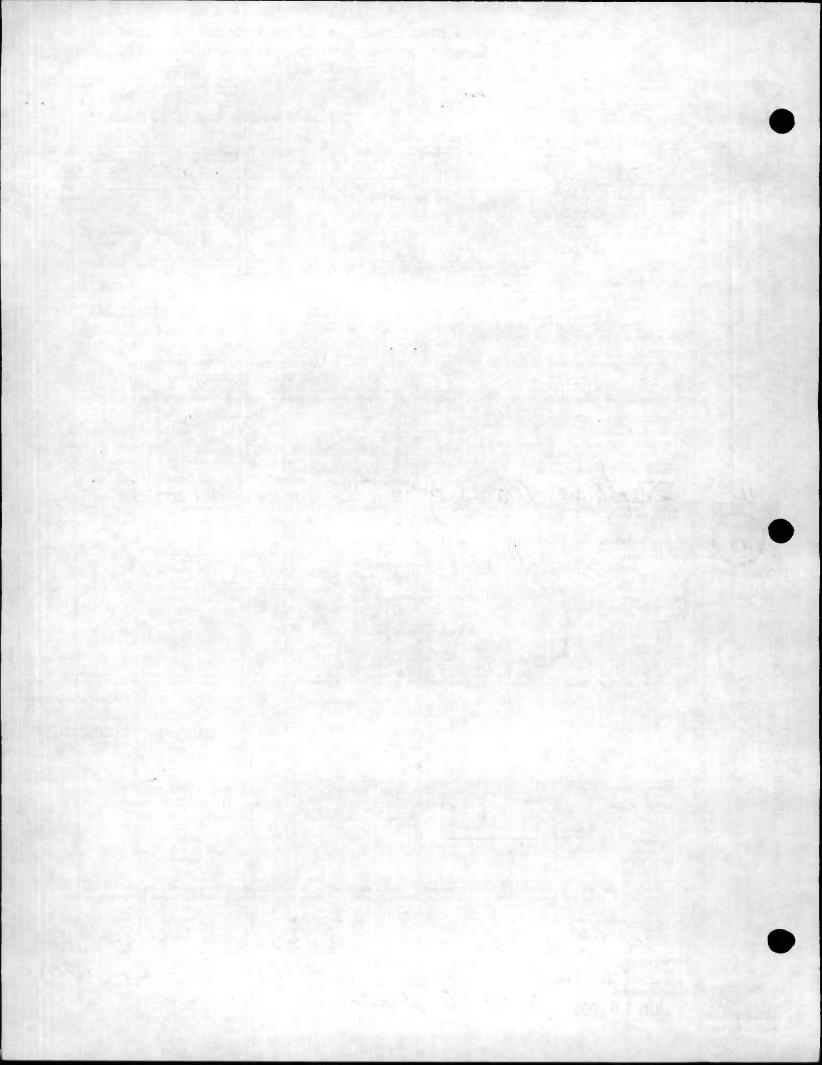
State Registrar F.E. Chathan

31. Dete filed (Month, Day, Year)

JUN 1 6 2000

, M.D.

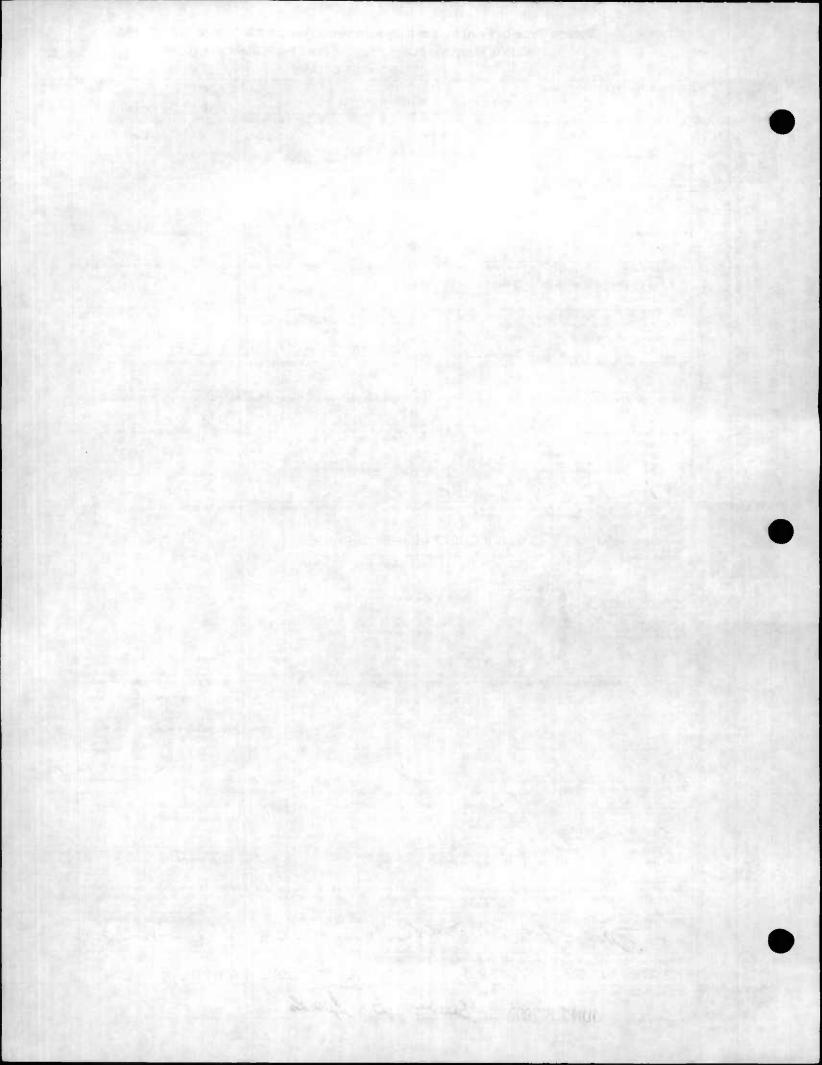
32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Yee **Physician** MELVIN JOHN TUROWSKI JUNE 1:54 AM 15, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Saint Joseph Medical Center Towson Baltimore If Under 24 Hrs. If Under 1 Yeer 8. Dete of Birth (Month, Day, Year) 8-5-1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** Deys Months 1 XM 2 F Houra 78 220-05-2124 Maryland Director Uauel Residence of Decedent death with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits natural, or hama 23a or 28a-f shording Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10a, Street and Number 2419 Cider Mill Road 21234 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yea or No-If Yea, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 TYes 2 No If Yes, Give WW II Yeer or Detes: 1 Never Married 2 Nerried 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: specify: White P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Longshoreman 12 yr's Maryland Ports 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Nem 27 Is marked other any Injury or other traumatic avent Be Turowski Bertha Konstanty 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Helen C. Turowski - Wife 2419 Cider Mill Road Baltimore, MD 21234 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) Dete 20c Location - City or Town, State 20a. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 6/19/00 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith 22. Name and Address of Facility Baltimore, Maryland 21214 21. Signeture of Funeral Service Licenses Leonard J. Ruck, Inc. 5305 Harford Rd. an 23a. Pert1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on a such as the death. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) INTRACEREBRAL HEMORRHAGE /Medical Examiner Due to (or as a consequence of) Examiner that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequença of): Box 68760. Physician/Medicai Due to (or es a consequença of) 98 980 ò P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 25 No 3 Probably 4 Unknown signed t Records, by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed D990 page 2 has 1 ☐ Yes 2 No 1 Yes 20 No certificate of Vital 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: Unpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yea 2 No After this 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera edical Certification: Division Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 6-15-2000 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANCIS KÁDO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 31. Dete filed (Month, Day, Year) - - 32. Registrar's Signeture

State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month THOMAS MADELINE 12:45 AM 11,2000 JUNE /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTERBALTIMORE NIA If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) MD 6. Sax 10 M 20 F **Funeral** 218 - 38 - 1234 Usuel Residence of Decedent Yrs. Director 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits pemit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show they fourly or other treumstic event, the Medical Examinat must be notified at page. BALTIMORE 1 Yes 2 No Director MO NA 10s. Street and Number 10f. Zio Code 10g, Citizen of What Country? 258 N. BETHE USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 12 No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, Whita, etc. 11. Merital Stetus 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use mitired) HOME DERVICE Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 TH GRADE TOOD NIA 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DOCK G. ELSIE MONROE LEIGLER 19e. Informent's Neme/Beletlonship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ST. MAIN VERNON 8920 (HOMAS AIRY. MD. 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) VOSHELL CEMETERY 16-16-00 BALTO . MO 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE aus 5151 BALTO NATE PIKE BALTO - MO. 21229 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediete Cause (Finel diseese or condition resulting In deeth) /Medical PNEUMOTHORAX 15 minutes Examiner Due to (or as a consequence of): Completed by Physician/Medical Examiner To the Hospital or Attending Physicien: The lew requires that the deeth certificate be executed within £2 khours after death. To the Funeral Difector: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the bunkal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): thet initiated events resulting in death) Last Due to (or es e consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No congestive aspiration pneumonia 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? heart failure completion of cause of death? 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical axeminar? 1 Yes 2 No Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 2 Accident 5 Pending Investigation

P.O. Box 68760, Division of Vital Records.

Baltimore, Maryland 21215-0020

State Registrar

ELIZABETH T. PYNADATH 31. Dete filed (Month, Day, Year) JUN 1 6 2000

Elizabeth T. Pynadath mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signeture end title of certifier

4940 EASTERN AVE. 32. Registrer's Signeture

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

BALTO.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

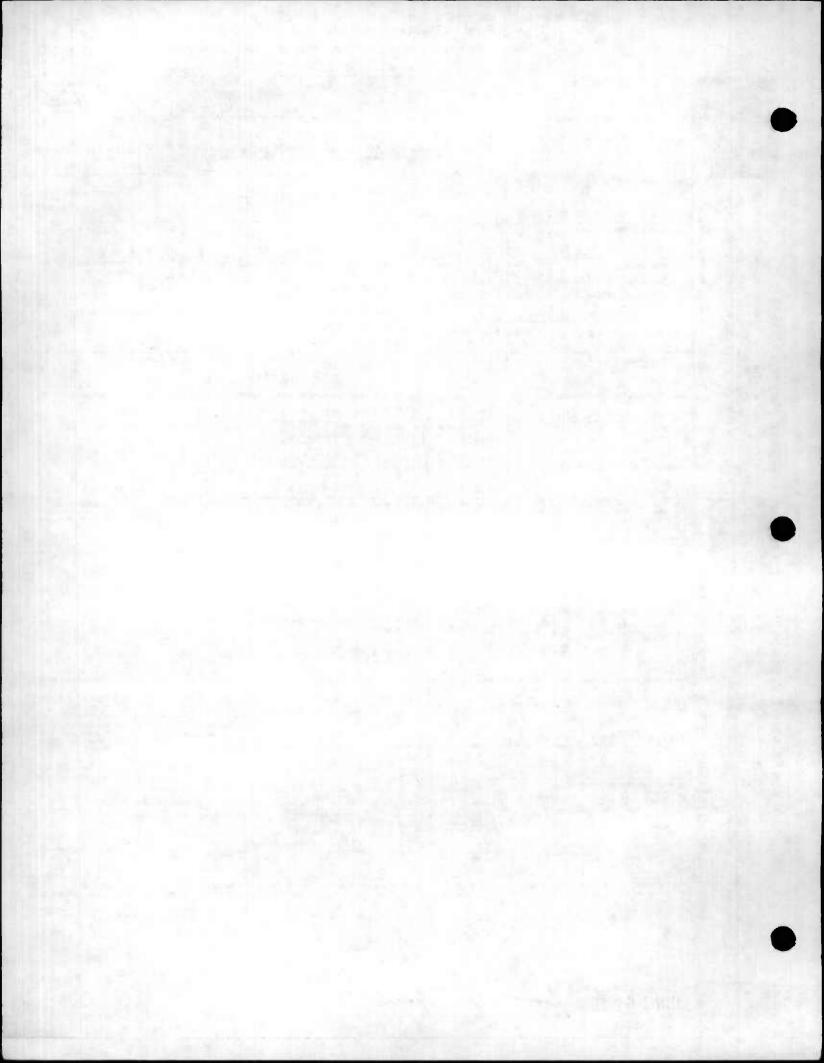
29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

MD . 21224

29d. Date signed (Month, Day, Year)

JUNE 11, 2000



#### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

	1. Decedent's Na	a, 27, 28 PFR M me (First, Middle, Last	)	7700 A	FI.			2. Dete of D		M	3. Time	of Death
sician	Joan E	rances Tho	mas					JUNE	10,20	Year	5:20	P.M.
edical miner	4a Fecility Name	(If not institution, give	street and number	)			4b. City, Town,	or Location of Dea		y of Deeth	7 3 8 20	
	SINAI HO	OSPITAL					BALTIM	ORE			1	
	5. Social Security 215-84	-7356 <sup>10</sup>	7. A	ge (In yrs. i 38	last birthday) Yrs.	If Under 1 Yee Months Days		s. B. Dete of B (Month, D Jan.	rth ay, Year) .4,1962		piace (State ntry) ningto	
	Usual Residence 10a. State	of Decedent		10c. City	y, Town or Loc	ation					10d. Inside	City Limits
10	MD	Baltimo	re	В	altimo	ce						s 2 🛛 No
Director	10e. Street and N	lumber				10f. Zip Code			10g. Citizen of	What Cou	intry?	
	3966 F	enhurst Av	enue			212	215		U	SA		
Dy ruilleral		erried 2 Married	12. Was Decedent Armed Forces' 1 ☐ Yes 2XI If Yes, Give Year or Dates:	7		/as Decedent of Yes, specify Cu		(Specify Yes or Nerto Rican, etc.)	o- 14. Ra Bla Speci	ack, White,	can Indian, etc. nite	
	10.	15. Decedent's Edu			16a. Deced	ent's Usuai Occi	upation	- dia	16b. Kind of E	Business/In	dustry	
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De		e (First, Middle, Last) Villiam Tho	mas					Jirginia		те/		
2		Name/Retationship (T)			19h Mailin	Address /Stree	-	Rurel Route Num		State Zi	p Code)	
		7. Thomas (						Edgewater				
	20a. Method of D			20b. P		sition (Name of setory or other p		Date	20c. Location		own, State	
		2XXCremation 3 F				ematory	ace)	2000	Baltim	ore,	MD	
		Funeral Service Licens		/	22	Name and Add	ress of Fecility	al Home,	D 7			X
	M	101.1.6	2) 7	11			_	aı nome, nue, Anna		MD 21	401	
Examiner	Immediate Caus disease or condi resulting in death	tion	COMBINED		NTOXICAT							
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Medical	that initiated eve resulting in death		d.	Due to (or	r as a consequ	ience of):						
Physician/M	Part II. Other sig	nificant conditions co	ntributing to death I	but not resu	ulting in the ur	derlying cause (	given in Part I.		d tobacco uee c	ontribute (		o of death
leten by								24a. Wa	s an autopsy formed?	a'	Vera autops vailable prio ompletion of death?	or to
Completed	1000							24	Yes 2 No	1	N	□ No
Bec	25. Was case re-	ferred to medicat						Death (Check only	one)			
10	1) es 2 27. Mannar of De 1 Natural 2 Accident	eath 5 Pending	1 □ Inpati 28a. Date of inj FOUND: 67	ury	ER/Outpetlen 28b. Time of Injury unknown	28c. in		g Home 5 Re	sidenca 6 🗆 O			INGEST
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edicai (	29a. Certifier (Check only one)	1☐ Certifying Phy 2☐XMedical Exami		of examinal								e(s)
0	29h Signature a	nd title of certifier	The state of			29c. Lice	nse number		29d. Date sign	ed (Month	, Dey, Year	)
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State

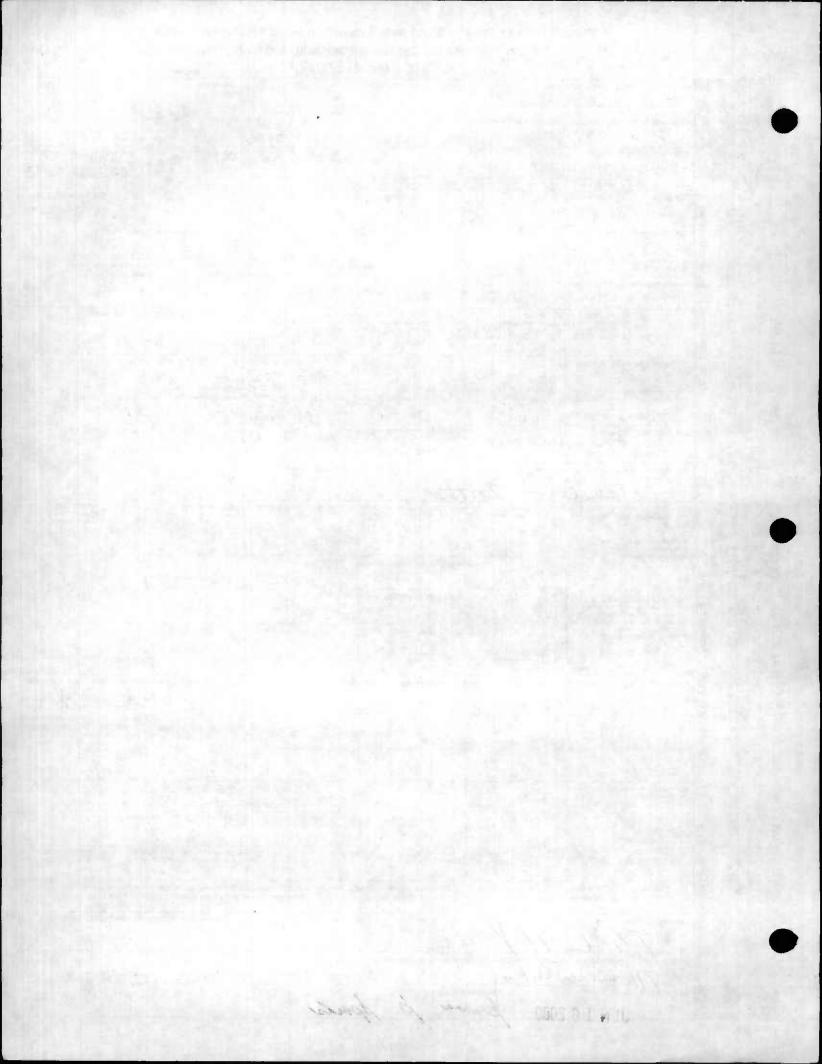
Registrar JUN 1 6 200

31. Date filed (Month, Day, Year)

32. Degistrar's Signature

111 Penn Street, Baltimore, Maryland 21201

9. Sports

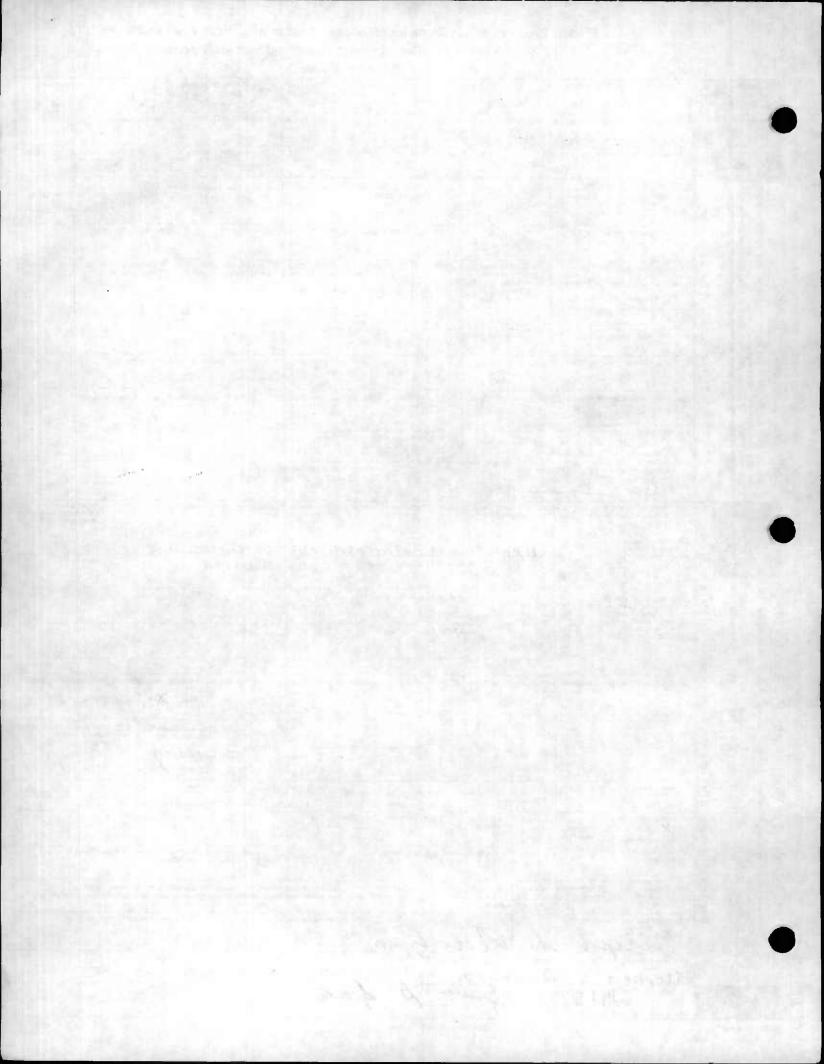


### Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				CEI	rtificate of	Doam		Reg	g. No.	0 12100
1. Decedent's Name (Fit Verna	irst, Middle, Las Louis		r				Mo	te of Death onth ne 14	Day	Year 8:22 P.M
4a Facility Neme (If not	t institution, give	street and numb	er)	14		4b. City, Town	1		4c. County	
		l Hospit					Burnie			Arundel.
5. Sociel Security Numb 524-30-8588	8 1	ex	Age (in yrs. i	last birthdey) Yrs.	Months Deys	If Under 24 Hours	Hrs. 8. De Min. (M Apr	te of Birth onth, Dey, il 4,	Year) 1929	9. Birthplace (State or Forei Country) Colorado
Usual Residence of Dec 10a. State 10b	b. County		10c. City	, Town or Lo	ocation				- 8	10d. Inside City Limi
Ca. S	San Die	go	Sa	n Marc	cos					1 Xyea 2□N
Ca. Street and Number 1219 East E		#31			10f. Zip Code 9206	9		10	g. Citizen of V U.S.A	What Country?
11. Merital Stetus 1  Never Merried 3  Widowed 4		12. Wea Decede Armed Force 1 Yes 2 If Yes, Give : Yeer or Dete	s? No		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☒ No		? (Specify Yourdon Rican,	etc.)		e - American Indien, ck, White, etc. w: White
(Specify or	Decedent's Ed	ucetion de completed)		16a. Deced	dent's Usuel Occup kind of work done DO NOT use retire	petion during most of	working	10	6b. Kind of Br	usiness/industry
Grade 12	ry (0-12)	College (1-4	or 5+)		nemaker	0,		1 34	Own H	ome
17. Father's Neme (First				pina)			Neme (First		aiden Sumen	70)
19e. Informent's Neme/	/Reletionship (7	Type, Print)		19b. Meilir	ng Address (Street					Stete, Zip Code)
Kim Vogler	/ 50			- 12	angdon F					
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21. Signeture of Funera	100	see	7.0	22	2. Neme end Addre Donaldso	esa of Fecility n Funer	J			varacy no.
Gry -	>.49	/M007	70		313 Talb	ott Ave	enue :	Laure:	l, Mar	yland 20707
tmmediete Cause (Fine disease or condition resulting in death)	el	a. Hyper			heroscle quence of):	ng, such as ca				Approximete Intervel Between Onset end Deeth
disease or condition resulting in death)  Sequentielly list condition if any, leading to immed	ions, diete ng	a. Hyper b	Due to (or		h x no sclx quence of):					Intervel Between
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State Registrar

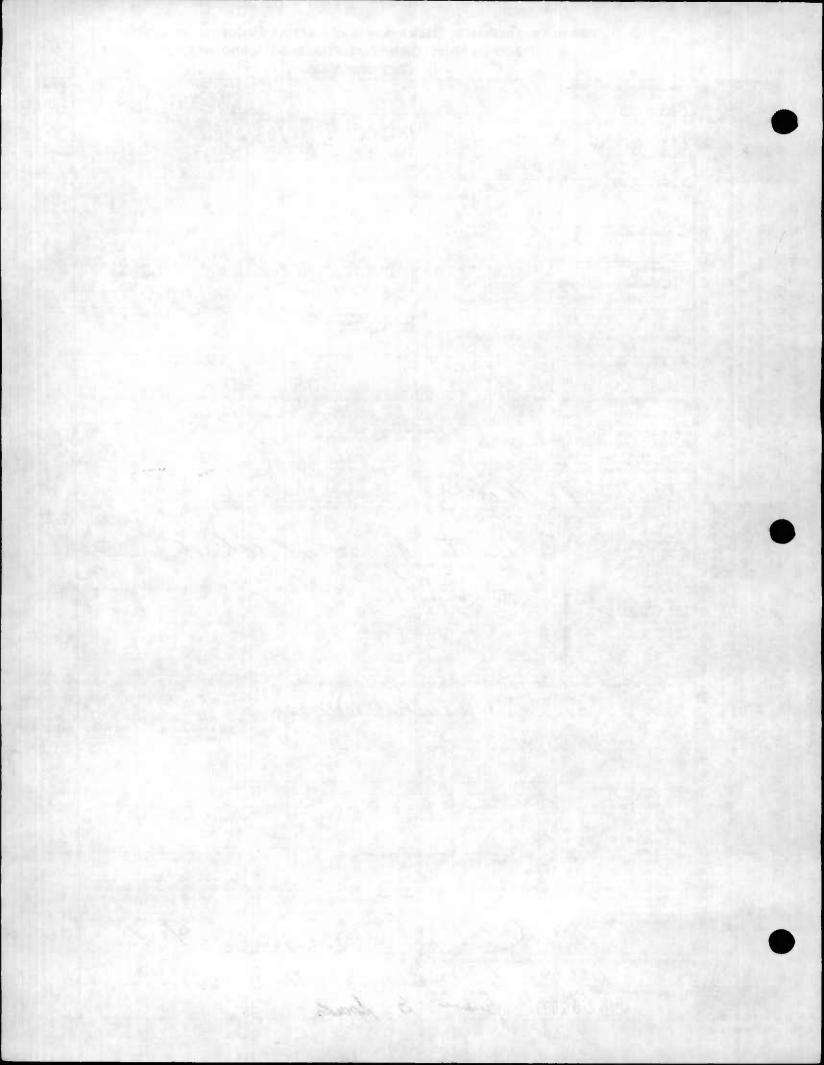


# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ician	11.	Decedent's Name (First, A	Aiddle, Last)	1/12/15			rtificate	0	outi,		2. Date of I				3. Time o	Death
dical		Sunildo Vel	azquez								June	2 9	2	Vear UUO	348	pn
niner		Facility Name (If not instit	fution, give str	and number	er) / 12-	1-10	0	<b>3</b> b.	City, Tow	m, or Lo	cation of De	ath 4c.		of Death		
	5.	Social Security Number	6. Sex	T.	Age (In yrs. la	st birthday)	If Under 1 Y		If Under 2		8. Dete of I	Birth Dey, Year)	N/		lece (State	or Forei
		42-42-8748		M 2□ F	65	Yrs.	Months D	ays	Hours	Min.	Dec 12	, 193	34		Repu	
		sual Residence of Deceder a. State 10b. Co			10c. City,	Town or Lo	cation							1	Od. Inside C	lty Limi
ctor		MD	N/	A		Balt	imore								1X Yes	2 🗆 N
Funeral Director		e. Street and Number .000 N. Gilmo	re Str	eet			10f. Zip Co	2122	23			10g. Cit		What Coun	itry?	
		. Marital Status  1 Never Married 2 3 Widowed 4 Divo	Married	. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Dete	ss? X) No		Was Decedent If Yes, specify 1 ☑ Yes 2 ☐				cify Yes or I Ricen, etc.)	No-	Blec	e - Americ ck, White, hisp	etc.	
		(Specify only his Elementary/Secondary (0-		tion completed) College (1-4	or 5+)	life. I	dent's Usuel O kind of work o DO NOT use r	done dui retired)	on ning most	of worki	ng	16b. K	ind of Bu	usiness/inc	lustry	
5	17	12 . Father's Name (First, Mic	idle ( ast)	0		re	pairma		8 Mother	r's Name	(First, Midd			scape	s	
0 0	M	Manuel D. Del							Ana M			io, maiocii	00,,,,,,,,,	.0,		
-	19	9a. Intermant's Name/Relat					ng Address (S	treet en	d Numbe			nber, City o	or Town,	State, Zip	Code)	
	_	Md General	Hospi	tal	20h Bla		Linden		e Ba	ltír	nore,		21201			
		a. Method of Disposition  1 □ Buriat 2 □ Cremat  4 □ Donation 5 ☒ Othe	er (Specify)	in sta	ate Ce	metery, crer	sition (Neme and other of the	r plece)		1	Date	20c. Lo	ocation -	City or To	wn, State	
	21	Rona L	S Wa	ide, Pi	rector		R. Name and A State A Baltimo			Board 2120		W. Ba	alti	more	Stree	t
	la.	Prit1. Enter the disees at ack, or heart failure.													Approxima Interval Be Onset and	Death
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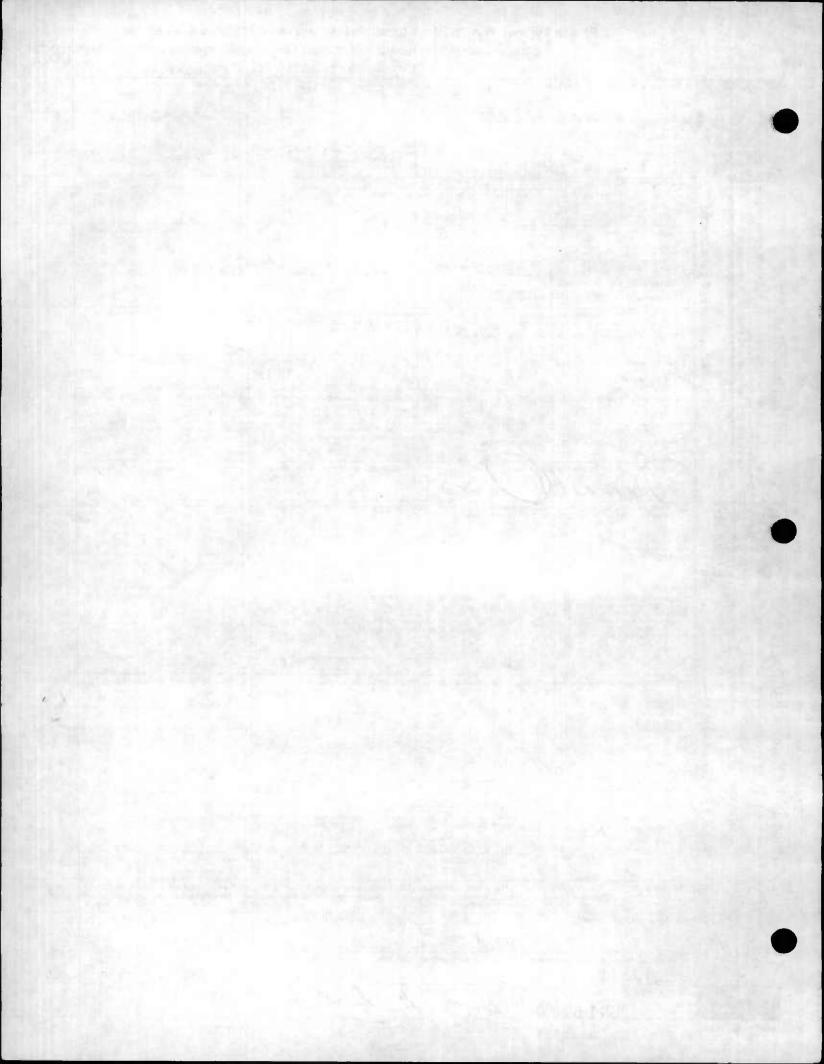
00-3175-510 Paul R. Walker JVW

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ıl R. Wa					Department	of He	ealth and	Mental Hy	giene ()	0 191	67
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/Med Exam		4a Facility Name (If not institution, gh Harbor Hospita				4t	. City, Town, Balti	June or Location of Dea		of Death	
Funera Directo		215-74-4611	· □ · · · □ =	e (In yrs. last bii 41	rthday) If Under 1 Months Yrs.	1 Yeer Deys	If Under 24 H Hours M	in. 8. Dale of 8 (Month, D		9. Birthplace (State Country) MD	
and with		Usuel Residence of Decedent  10e. State 10b. County	Therese	10c. City, Tow	m or Location	-				10d. Inside	City Limits
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ith with the Marylan 23a or 28a-f show	Direc	10e. Street and Number		871	10f. Zip (	Code			10g. Citizen of V		1
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5-UUZU 72 hours after death with the Maryland natural', or items 23a or 28af show stell Examiner must be notified at	by Funeral Director	11. Marital Stetus  1 Never Merried 2 Married  3 Widowed ***CDivorced	12. Was Decedent Armed Forces?  1 Yes 2020 If Yes, Give Year or Dates:		13. Was Decede			(Specify Yes or N erto Rican, etc.)	Specify	ck, Whita, etc.	
4 VIZI 5-0020 d within 72 hours af glene. rr than "natural", or y as Medical Even	ted	t5. Decedent's E (Specify only highest gr		16e	Decedent's Usuel	Occupa	ion	working	16b. Kind of B	usiness/Industry	
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	Co	12th Grade  17. Father's Name (First, Middle, Last	NĂ NĂ		Handy m		18. Mother's N	leme (First, Middle			; Mar.
should be and Mental in merked of urmatic eve	o Be	Roosevelt	Walke	r			Lilli			mith	
T to		19e. Informent's Name/Relationship ( Joann Rice								State, Zip Code) 2	
0 - 1 E 5		20a. Method of Disposition  ¥☐ Burial 2 ☐ Cremation 3 ☐		20b. Plece o	of Disposition (Nam-	e of her place	)	Date	20c. Location -	City or Town, State	
nit. Pages antment of ortant: If its injury or o		4 □ Donation 5 □ Other (Special	fy)					5-17-20	00 Lans	downe, M	ID
Departition of the post of the		21. Signature of Funerel Service Lice	Il las	de	22. Name end					yland 21 Avenue	202
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a deat	sicia	Part II. Other significant conditions of	contributing to death b	ut not resulting i	in the underfying ce	use give	n in Part i.	23b. Did	tobacco usa co	ntribute to the caus	a of death?
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The law	дшо							1	Yes 2□No	of deeth?	□ No
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ding Ph Affer th funeral		27. Menner of Death 1 □ Netural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)		Sc. Injury Work			how injury occur	red	
LIVISION  or Attending wher death. Director: After d in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☒ Could not be			KNOWNM		es 20 No		NOWN	ber of Rural Route No	imher
or Attentant after deat Director:	ertif	4 ☐ Homicide determined		c. (Specify)	arm, street, factory.	Office		City or T	own, State) 112	CHERRY H	ILL RI
Hospita 14 hours Funeral tely fille	edical C	29a. Certifier  (Check only one)  1 Certifying Pt  2 Didedical Exam	nysician: To the best of miner: On the basis of end menner ste	of my knowledge examination ar	e, deeth occurred and/or investigation,	t the time	e, date and ple inion, death o	ece, end due to the	ORE, MD cause(s) and ma dete and place,	anner as stated. and due to the cause	e(s)
of the second	Med	295. Signature and title of certifier /	A Commenter Ste		29c.	License	number		29d. Dete signs	d (Month, Day, Year,	)
110	/	Mant	orlean			.C.M	i.E.		June	09, 2000	0
111		30. Nems and address of person who	E MA O	eath (Item 23a)		Pen	n Stre	et, Balt	imore. M	aryland 2	1201
S	tate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signeture	, /	all					
Regis	trar	JUN 1 6 20	100 Ben	we	12 M	may					
DHMH 16 Ray 6	/95		-		-						

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ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death Dey Year **Physician** Month GEORGE WILLIAMS 7:40 PM 2000 JUNE 12 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OF BALTIMORE BALTIMORE BALTIMORE GOOD SAMARITAN HOSPITAL 8. Date of Birth (Month, Day, Year)

MARCH 8, 1934

9. Birthplace (Steta or Foraign Country)

NORTH CAROLINA If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 12 M 2□ F 7. Age (In yrs. last birthday) **Funeral** Days 217-34-918: Usuel Residance of Decedent 66 Director 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director BALTIHORE MARYLAND or 28a-f 10e, Street and Number 10g. Citizen of What Country? 238 ROAD 21214 700 HARFORD Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 Xyas 2 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Merried 2 Married b 1 ☐ Yes 2 XNo Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondary (0-12) STHGRADE Coilege (1-4or 5+) MECHANIC 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fin tment of Health and Mental He tant: If item 27 is marked oth Be BEATRICE WILLIE 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NATHANIEL RIDLEY MCCLEAN BLVD, BALTIHORE, MD. 21234

tion (Name of Date 20c. Location City or Town, Stata them 27 i 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Department of important: If it any injury or o 1 ☐ Buriel 2 Cremation 3 ☐ Removel from State 6-15-00 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) METRO CREMATORY 22. Name and Address of Facility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME & 140 N. FULTON AVE. BALTIMORE, MD. 2131 21. Signature of Fundral Service Liogo BROWN JR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical SEPSIS Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentielly list conditions, if any, leeding to immediate ceusa. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): the Due to (or es a consequence of): 88 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ page 2 should be 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Wes an autopsy performed? 1 Yes 2) No 1 ☐ Yes 2 No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

sician and burial-transit The law requires that the death certificate be executed P.O. Box 68760. Records, certificate Division of Vitai or Attending Physician: Medical Certification: To After this 24 hours after death. Funeral Director: A filled in by

filed within 72 hours after

3altimore, Maryland 21215-0020

1 Yes 28 No 27. Menner of Death Natural 2 Accidant 5 Pending

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

28e. Dete of Injury (Month, Dey Year) investigation 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Bahl

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) GOOD

Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No 28d. Describe how Injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the causa(s) and menner stated.

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signeture end title of certifier Marrisha

M.D.

29c. License number 13452

5601

29d. Date signed (Month, Day, Year) 2000. JUNE

LOCH RAVEN BOULEVARD

BALTIMORE, MARYLAND 21239

BAHL MANISHA 31. Date filed (Month, Day, Year)

JUN 1 6 2000

32. Registrer's Signature

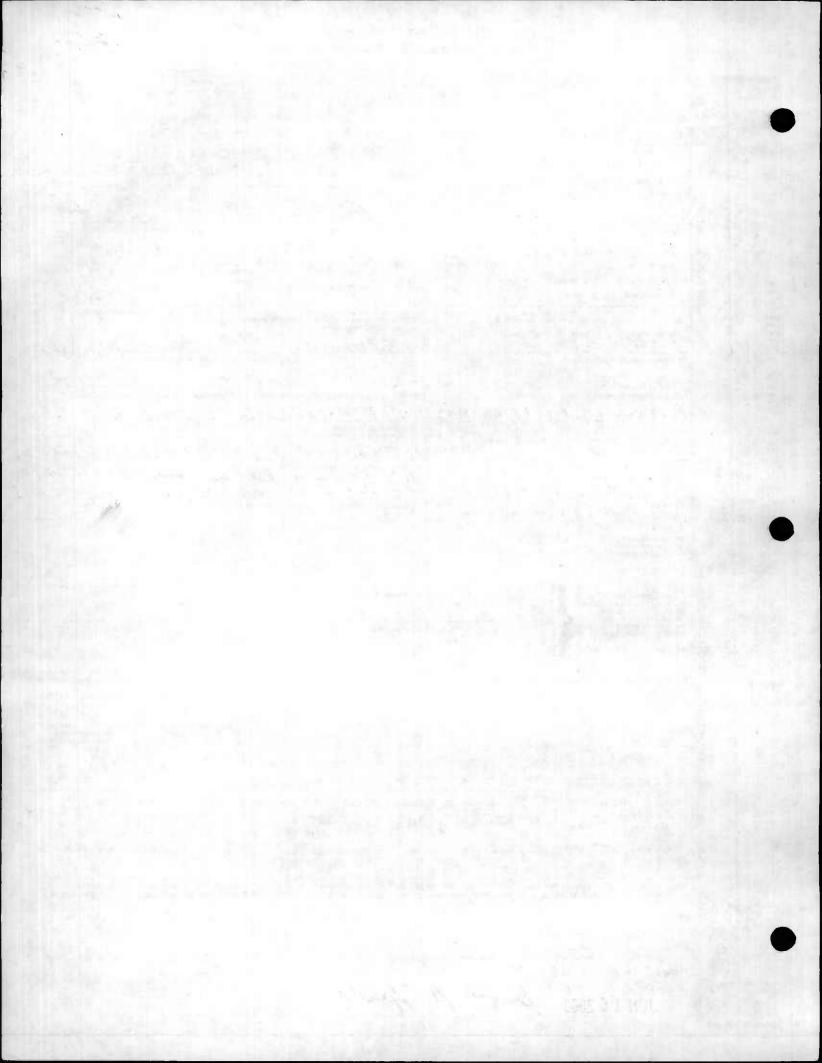
SAMARITAN HOSPITAL

State Registrar

completely

within 2 \$

Hospital



#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year 8:35 am Anna Elizabeth White June 13, 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mary's Country Acre Highland Howard 5. Social Security Number if Under 1 Yaar if Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 1 M 2 XF Months Days Hours Yrs 577-14-6943 Apr.17, 1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1∏Yes 2□No Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Prince George Street 20707 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Biack, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Surname) Dewey Brown Loretta Divens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Charles D. White/Son 11260 A Powder Run, Columbia, Maryland, 21044 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other placa) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/15/00 Laurel, MD Ivy Hill Cemetery 22. Nama and Address of Facility Donaldson Funeral Home, P.A. MOO773 313 Talbott Avenue, Laurel, Maryland, 20707 23a. Part1. Enter the distributions or complications that caused the death. Do not enter the mode of dying, such as cardiac or rasptratory arrest, shock, or hear distribution is List only one cause on each line. Approximata Interval Between Onsel and Death Immediate Cause (Final disease or condition resulting In death) Metastatic Ovarian Cancer 7 years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2CXNo 1 ☐ Yes 2XXNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Homa 5 Residence 6X Other (Specify) Assisted 1 Yes 2√2 No 1 Inpatient 2 ER/Outpatient 3 DOA Living 27. Manner of Death 28a. Date of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

**Physician** /Medicai Examiner

**Physician** 

/Medicai

Examiner

Director

Funeral

þ

Completed

Be 2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth end Mental Hygiene.
Important: If Item 27 Is marked other than "naturel", or Items 23s or 28s-1 show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed Physician/Medical Exami ettending physician end for use es the buriel-tran signed t page 2 s director this

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Completed

Be

P

Certification:

cal

Records, P.O. Box 68760.

Division of Vital

or Attending Physician: To the Hospital or Attending Phy within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral of

Clara 31. Data filed (Month, Day, Year) State Registrar JUN 16

1 X Natural

2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

one)

29b. Signature and title of certifier

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Chan, MD

5 Pending investigation

6 Could not be determined

9801 Georgia Avenue, #337, Silver Spring, MD 32. Registrar's Signature

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

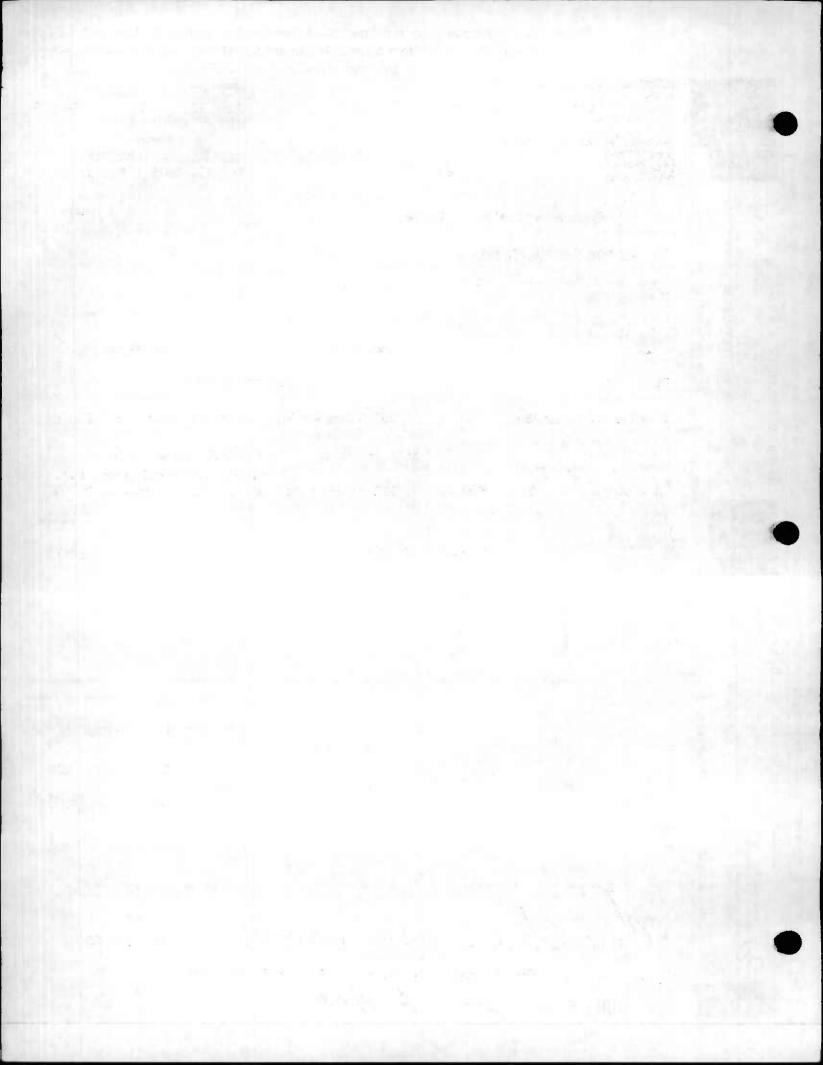
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29d, Date signed (Month, Day, Year)

June 13, 2000



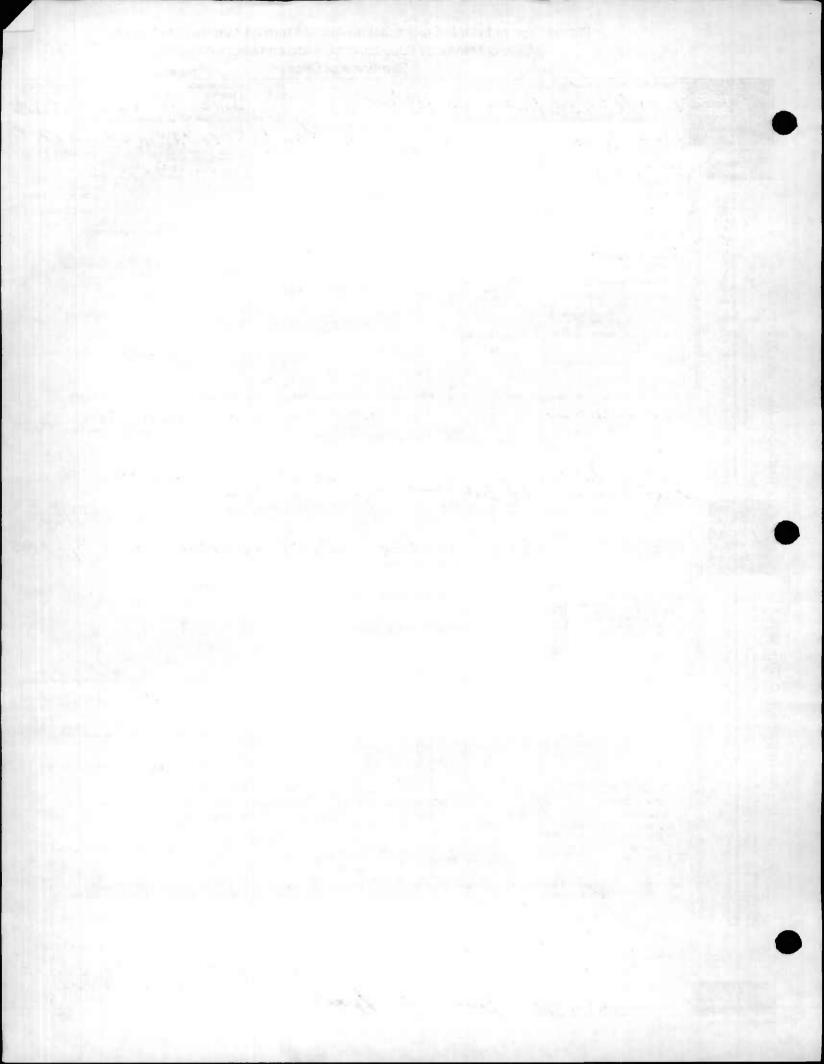
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** AVARENC 4a. Facility Name (If not institution, give street and number) INTHONY UNB 2000 725 A.M. /Medical 4c. County of Deeth 4b. City, Town, or Location of Death **Examiner** Under 24 Hrs. 8. Dete of Birth (Monty, Day, Oct 24, TIMORE 5. Sociel Sacurity Number 05 11510WH 0 If Under Months 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthdey) **Funeral** Hours 58 Director 217-38-7688 MD Usuei Residenca of Decedent with the Maryland 10b. County 10e. Stete liem 27 is marked other than "natural", or tiems 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits MD Baltimore Reisterstown Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 112 Walgrove Road 21136

13. Wes Decedent of Hispenic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U,S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Bleck, White, atc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elamentery/Secondery (0-12) College (1-4or 5+) 12 financial mit. Pages 1 and 2 should be file partment of Health and Mental Hyportant: If Item 27 le marked oth y Infury or other traumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Malden Sumema) Be George Wist Regina 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Janet Wist/spouse 112 Walgrove Road Reisterstown, MD 21136 20b. Pleca of Disposition (Name of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If i any injury or 4 Donetion 5 Other (Specify) 21. Signature of Funeral Servica Licensee Ronald S. Wade, 22. Name end Address of Fecility State Anatomy Director Board 655 W. Baltimore Street naury 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician Immediate Ceuse (Final disaesa or condition resulting in deeth) /Medical a AT HEROSELEROTIC (DR dio VASCI/AR Disense
Due to (or es a consequence of): Examiner Examiner attending physician and I for use as the bunal-transit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequença of) signed by the a Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 2000 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 2 this funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred After t Attending 5 Pending investigation 1 Naturel Injury death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) 29a. Certifier Medical end menner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) who comple eted cause of deeth (Item 23a) (Type, Print) Rederick Kort Cato 400 IN NE AM50 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 1 6 2000

**DHMH 16 Rev 6/95** 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** WINSLOW 2000 7:15 Am MICHEAL JUNE /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner NIA HOSPITAL BALTIMORE HARBOR CENTER If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 □ F Months Days Hours 36 82-1074 Director Usual Residence of Deceden the Maryland 10d. tnside City Limits 10a. State 10b. County 10c. City. Town or Location ?? Is marked other than "natural", or items 23s or 28s-f show traumetic event, the Madical Examiner must be notified at 1 1 Yes 2 □ No Director BALTIMORE Mo 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code death with STREET 21202 1101 N. CALVERT USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Race - American Indian, Black, White, etc. 11. Merital Stetus filed within 72 hours after 1 Never Married 2 Merried altimore, Maryland 21215-0020 Specify: BLACK 1□Yes 2☑No Specify: Àq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usp ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) SALES BANKING ASSOCIATE 12 TH GRADE YRS 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
Important: If Item 27 Ia marked oth
any Injury or other traumetic event Be BERNADINE KODNEY WINSLOW JOHNSON 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BALTO. LOUGLAS MOTHER 458 UXFORD MO. 21201 BERNADINE 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete CATHEDRAL CEMETERY 6. 4.00 BALTO. MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 21229 5151 BALTO. NATL' PIKE, BALTO. MO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or harm failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical tmmediate Cause (Finel disease or condition resulting in death) SEPSIS 10 DAYS Examiner Due to (or as a consequenca of) Examiner 13 YEARS A. I. D. S attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CARDIOMYOPATHY Box 68760 1 MONTH certificata be Physician/Medicai Due to (or as a consequence of) 88 RENAL INSUFFICIENCY 1 MONTH ed by the a Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown HEART FAILURE CONGESTIVE Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed page 2 certificate has 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 0 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Dey Year) Certification: 27. Menner of Death 28b. Time of Injury 28c. tnjury at Work? 28d. Describe how injury occurred **√** Natural 5 Pending investigation spital or Attendin hours after death. nerel Director: Ah 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D Hospital UC Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end placa, and due to the cause(s) and menner stated. 29a. Certifier edicai completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number Ashakul (MD) 2000 RES OOD JUNE 30. Name and address of person who completed cause of deeth (item 23e) (Type, Print) BALTIMORE AMNA SHAKIL, 3001 S. HAMOUER STREET. WD 51552 31. Date filed (Month, Day, Year) 32. Registrar's agnature State Registrar JUN 1 6 2000

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Death 40 AM Month Day LYASES WILSON 2000 06-10-4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE +UTURE **IKESVILLE** 8. Data of Birth (Month, Day, Year) If Under 1 Yaer | If Undar 24 Hrs. 9. Birthplaca (Stata or Foraign Country) 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) Days Min Months Hours toM 20 F 216.34.0050 MD Usual Rasidence of Decedent 10a. Stata 10c. City. Town or Location t 0b. County t0d. Inside City Limits t ☑Yes 2 ☐ No NIA BALTIMORE MD 10g. Citizan of What Country? title. Street and Number t Of, Zip Code 21228 USA BEAUMONT 356 4VENUE 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No t 4. Race - Amarican Indian, Black, White, atc. 11. Marital Status t Never Married 2 Married t□Yas 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: t 6a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retiged) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantery/Secondery (0-12) Coilega (1-4or 5+) KESEARCH ANALYST VEFENSE DEPT. YRS GRADE 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surneme) WILSON LYSSES EDITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stata, Zip Coda) WILSON BEAUMONT BALTO, MD. BETTY 20b. Plece of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date t ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata GARRISON FOREST UWINGS MILLS, 6.15.00 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensea 22. Nama and Addrass of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Part I. Enta (the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. BALTO. Approximate Interval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in death) Monio Sequantially list conditions, if any, laading to immadiate causa. Enter Underlying Ceuse (Disease or injury that initiated evants rasulting in death) Last Due to (or as e consequance of) Dua to (or as a consequance ot): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? t ☐ Yes 2 ☐ No 1 Yas 2 No 25. Was casa ratarred to medical axaminar? 28. Place of Daath (Chack only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Yas 2 No t ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending Invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 28t. Location (Street end Number or Rural Routa Number, City or Town, Steta) 6 Could not be 3 Suicida 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicida

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2☐ Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number

4086

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29d. Data signed (Month, Dev. Year)

BALTO MO 21208.

Box Records, Division of Vital septal or Attending Physician: Thours after death.
Ineral Director: After this certificate filled in by the funeral director, pa

The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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To the Hospital within 24 hours a To the Funeral Completely filled Registrar **DHMH 16 Rev 6/95** 

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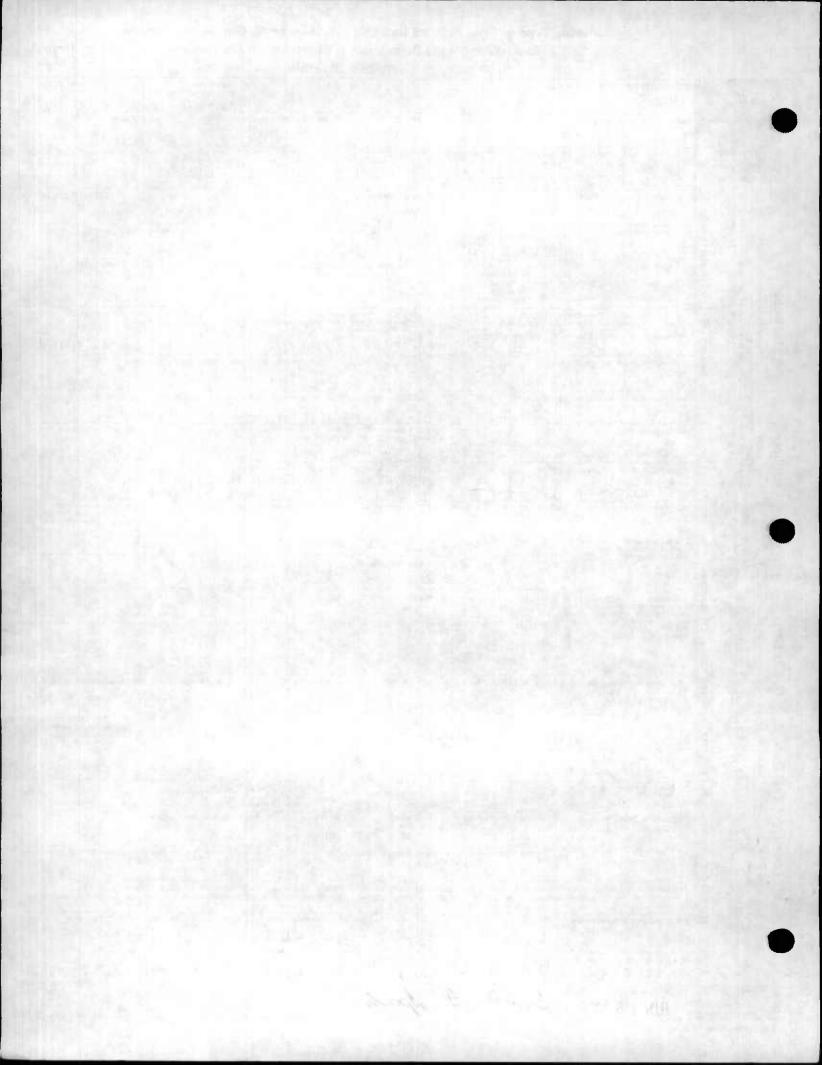
29b. Signetura and titla of certifian

30. Name and address of person who completed causa of daeth (Item 23a) (Type, Print)

M (6 Vel PA) VN (4 M) 32. Registrar's Signatura

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**ORIGINAL** 



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

Warren Weaver

State of Maryland / Department of Health and Mental Hygiene 00 10172

AMEND ITEM	MS: #23 PART I, 27, 28A	A-F PER MEO G784 6	-27- <b>©ertificate</b> d	of Death	F	Reg. No.		2110
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Physician /Medical	WARREN WRIGHT	WEAVER			June	11 2	2000	12:20 A.M
Examiner	4a Facility Name (If not Institution, give	re street and number)		4b. City, Town, or I	ocation of Death	4c. County	of Death	
	Bon Se	cours Hospital		Baltin		1	I/A	100
Funeral Director		Sex 7. Age (In yrs. 84	last birthday) If Under 1 Yes. Months De		8. Date of Birt (Month, De) 12 - 31	v. Year) -15	9. Birthp Cour	place (State or Foreign htry)
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all the state of t	WARREN WEAVE	R SON	8014 SUNST	DNE CIR.	PIKESV	ILLE !	MD.	21208
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/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Due to (d	HYPERTHEI or as a consequence of):	MIA				
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withir To th comp	29b. Signature and title of certifier	01	29c. Lic	ense number		29d. Date signe	d (Month,	Day, Year)
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	Dennis J. C.	completed cause of death (Iter	111 Penn S	treet, Bal	timore,	Marylan	d 21	201
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UNA 0 2000 John L. James

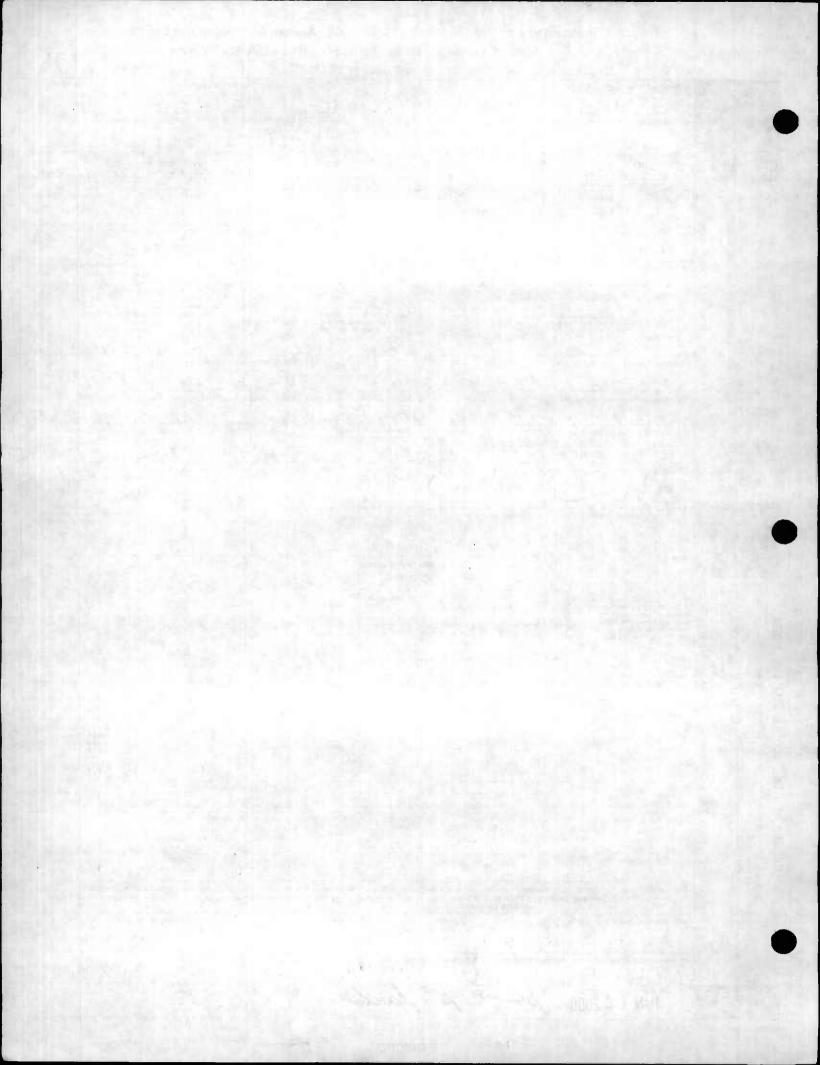
00-3051-510 mnmr James Young

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth Day Month **Physician** ANTHON JAMES 2000 1105 am June 02, /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Baltimore 1409 Ramsey Street N/A 8. Dete of Birth Month, Dey If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Hours Months Days 12M 2 F 216-78-436 39 Yrs. 12,1960 Director MARI Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yas 2 No Funeral Director MARYLAND 10f. Zip Code 10g. Citizen of Whet Country? 10e Street and Number 23a or 40 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. or items 11. Maritel Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married 1 Tes 2 No Specify: altimore, Maryland 21215-0020 þ BLAC 3 Widowed 4 Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygien Important: If them 27 Is marked other the any Injury or other transments. 12+4GRADE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be FORD IOSEPH TRACIE 2 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) A D 14 E D MO
 Placa of Disposition (Name of cametery, crametory or other place) AVE. BALTIMORE, MD. 21229 EDMONDSON GRACIE M. FORD 20c. Location - City or Town, State Dete 20a. Method of Disposition 18 Burial 2 Cremation 3 Removal from State STAP CEMETERY6-17-00 CATONSVILLE, MARYLAND 4 Donetion 5 Other (Specify) 21. Signatury of Funeral Service Lican 22. Name end Address of Facility
JOSEPH 1+, BROWN JR. FUNERAL 2140N, FULTON AVE, BALTIHORE, MO, 2121 Approximete Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory direct, shock, or heart tellure. List only one ceuse on each line. **Physician** /Medical Immediete Ceuse (Final Narcotic intoxication disease or condition resulting in deeth) Examiner Due to (or as e consequenca of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, attending physician Physician/Medicai Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably 4 Unknown þ 24e. Was an autopsy performed? 24b. Were autopsy tindings available prior to Completed completion of cause of death? 2□ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) at SCENE Certification: To 1X Yes 2 No apital or Attending Physical Prous after death.

neral Director: After this y filled in by the funeral di After this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation Found: 6-2-00 1 Yes 2 No Unk. Unknown 2 Accident 6 ☑ Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 1409 Ramsey St., Baltimore, MD within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axeminetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29s. Certifier completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signate and title of certifier O.C.M.E. June 03, 2000 am addrass of person who completed cause of death (Item 23a) (Type, Print) M 111 Penn Street, Baltimore, Maryland 21201 LON te filed (Month, Dey, Year)
JUN 1 6 2000 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Deeth Day Month Yaar **Physician** ELSIE ZIEGLER June 15, 2000 4:05 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis - Cromwell Center Baltimore Part 1 Baltimore If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Dey, Year) 10-7-1915 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 287F Days 84 Yrs Director 217-05-9194 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ahow 7 is marked other than "natural", or items 23s or 28s-f abov traumetic event, tra Medical Examinar must be incitived at N/A Baltimore City 1 X Yas 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1903 Wadsworth Way 21239 U.S.A. deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status pernit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mentel Hyglane. Introctant: if Item 27 is marked other than "natural", or the important: if Item 27 is marked other than "natural", or the eny injury or other traumado event, the Medical Examinat Dece. 1 Never Married 2 ☐ Married 1 Yes 2 No No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8 yr s College (1-4or 5+) Quality Control Alberd Goetz Meats 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middle, Last) 8 Katherine Bradlev George Ziegler 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Kenneth Ziegler - Brother 1633 Thetford Road Baltimore, Maryland 21286 20b. Place of Disposition (Nama of cemetary, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 D Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/17/00 Baltimore, MD Lorraine Park 21. Signature of Funeral Service License 22. Name and Address of Facility Baltimore, Maryland 21214 5305 Harford Road Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each fine. **Physician** fmmediata Causa (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner ettending physician and for use as the buriel-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to complation of cause of death? Completed 24a. Was an eutopsy performed? 1 Yas 20-No Division of Vital 25. Was case refarred to medicat axaminer? 8 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) After 1 Natural 5 Pending investigation ne Hospital or Attending in 24 hours after death. The Funeral Director: After spletaly filled in by the fur 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the H.
within 24 h.
To the Funs. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

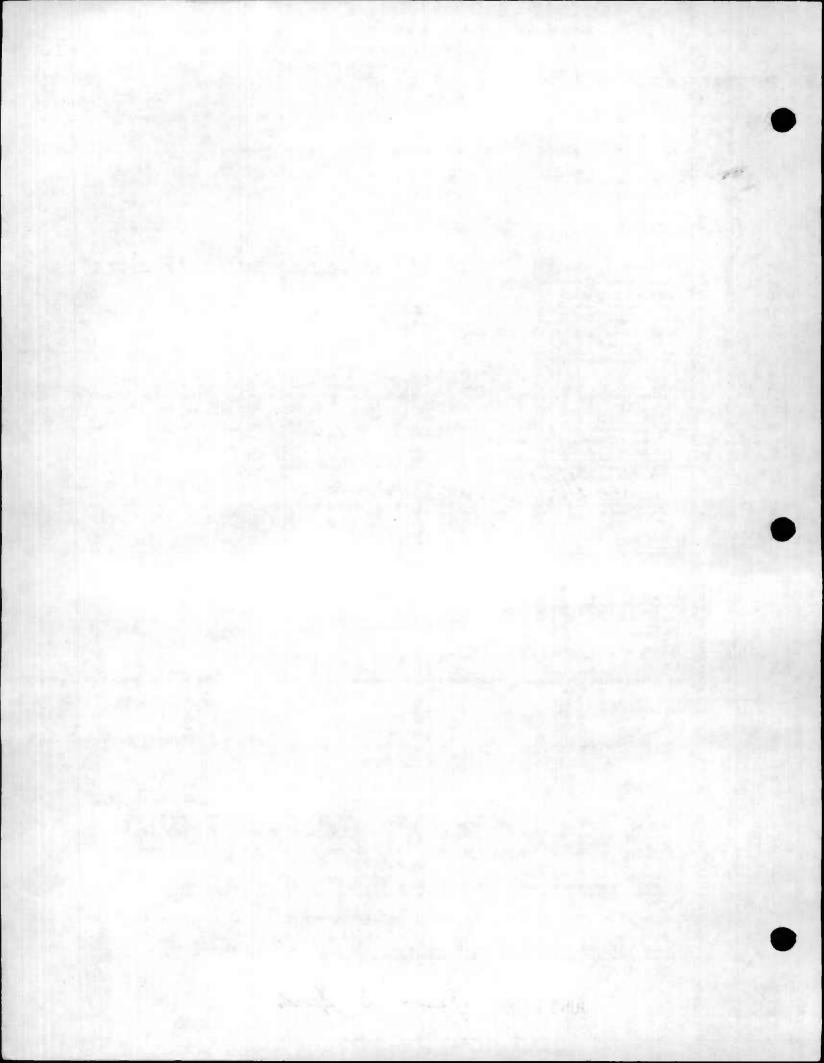
DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

32. Registrar's Signatura

2 Northum

31. Data filed (Month, Day, Year)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

U.S.A.

14. Rece - American Indien, Bleck, White, etc.

Construction

20c. Location - City or Town, Stete

Clinton, Md.

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Approximata Interval Between Onset end Death

3. Tima of Death

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	Examiner	4a Facility Name (If not institu RT.95 & RT.495		umber)		4b. City, Town, or BELTSVII		4c. County PRINCE	of Death	RGES
	Funeral Director	5. Sociel Security Number 227-50-0093	6. Sex 1⊠ M 2□ F	7. Age (In yrs. last birthday) 58 Yrs.	If Undar 1 Yaa Months Dey	r If Undar 24 Hrs	8. Date of Birth		9. Birthp	

P.G.

10c. City, Town or Location

Upper Marlboro

other than "natural", or items 23e or 28e-f vent, the Medical Examiner must be notified hours after

is marked

Baltimore, Maryland 21215-0020 72 filled within owmit. Pages 1 and 2 should be Department of Health and 44 Important: If have Mental Mental

**Physician** /Medical Examiner

The law requires that the death certificate be executed bunial-tran pue physician the USB 85 for ed by the a signed by t hes page 2 certificate Physician: director this funeral After Attending

Box 68760.

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Division of Vital

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Usual Residence of Decedent 10a. Stete 10b. County Md. Directo 10a. Street and Number Funeral 11. Maritel Stetus þ Completed Be 20a. Method of Disposition Immediate Cause (Final disease or condition resulting in death)

27. Manner of Death 1 Diaturel 2 Accident 3 ☐ Sulcida 4 T Homicide

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10f. Zip Coda 20772 8518 Old Colony Drive 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas ※ ※ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2X Merried 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) 6th College (1-4or 5+) Laborer 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maiden Sumame) Adel Sydnor Willie M. Adams 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 3005 Bladensburg Rd., N.E. #909, Wash., D.C. 20018 Savannah Adams/ Wife 20b. Placa of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Forest Hills Mem. Gdns.6/7/00 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
H.S. Washington & Sons Co., Inc. 21. Signature of Funerel Service Licensee W. Shall 4925 Burroughs Ave., N.E., Wash., D.C. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. MUMME Due to (or as a consequenca of) Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or es a consequenca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signatura

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31. Dete filed /Mi

23b. Did tobacco use contributa to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings availeble prior to completion of cause of death? 24a. Was an autopsy performed? 1 Ses 2 No 1€Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ùXYes 2□ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Control (Specify) SCENE 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 5 Pending invastigation 16409 1 Yes 2 No DRIVER OF OUR WORLD OPETHE FOUND 5-27-00 6 Could not be determined 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stata) 28e. Pleca of Injury - At home, ferm, street, factory, office building, atc. (Specify) RTGT PRIME GOODIES Wo - MY DISTURY 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated. 29a. Certifier (Check only Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. onel 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifier MAY 28,2000 O.C.M.E.

State Registrar

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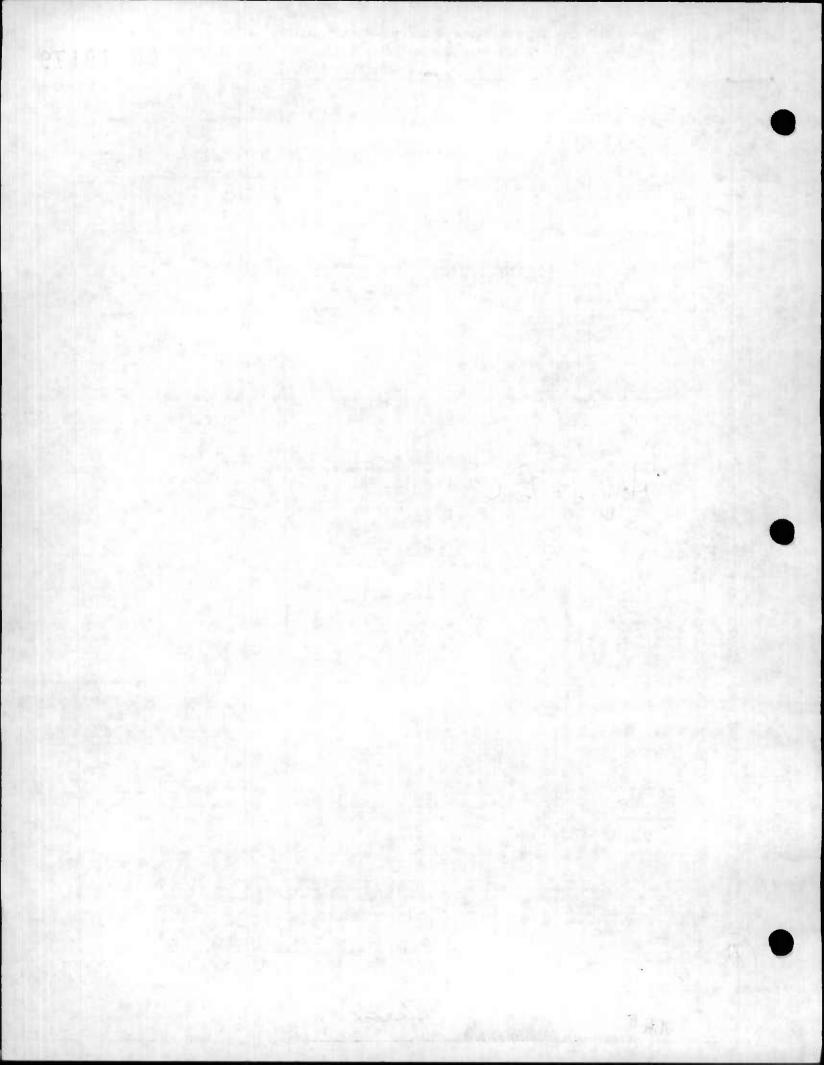
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State of Maryland / Department of Health and Mental Hygiene 00

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month May **Physician** Carol L. Bischoff 30, 2000 1705 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, giva street end number) 4c. County of Death Examiner Laurel Regional Hospital Prince Georges Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 24, 1925 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplaca (Steta or Foreign Country) **Funeral** Months Days Hours 1□ M 2₩ F 74 006-20-1511 Yrs. Director Ohio Usual Rasidence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If items 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other tranmatic event, my Medical Expiriter must be notified at 10c. City. Town or Location 10d. Inside City Limits / is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Md. Prince Georges Bowie 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9201 Laurel Bowie Road 20720 USA Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Rece - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fethar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Meidan Sumema) Be Scott Lyons Natalie 2 McMannus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) John M. Bischoff - husband 9201 Laurel Bowie Rd., Bowie, Md. 20720 20b. Place of Disposition (Neme of cematery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 06-03-00 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Lakemont Mem. Gardens 4 □ Donation 5 □ Other (Specify) Davidsonville, Md. 21. Signature of Funeral Servica Licensee, 22. Name and Address of Facility Beall Funeral Home Robert G. Beall M00025 6512 N.W. Crain Hwy., Bowie, Md. 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Causa (Finel Disseminated intravascular coagulation 3 days disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner Cancer widespread of unknown origin 2 months The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of): and P.O. Box 68760, physician Physician/Medical the Due to (or as a consequence of) attending for usa as signed by the a Part II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown deep venous thrombosis, renal failure, Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy peen upper GI bleeding with anemia, paga 2 cerebrovascular accident 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yas 2 No 1 Nonpatiant 2 ER/Outpatient 3 DOA funeral 28c. Injury et Work? 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Injun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide F • Funeral Di lataly filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) end manner steled. edicai 29a. Certifier To the Hosp within 24 ho To the Fune complataly fi (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 6 30. Neme and eddress of person who completed ceuse of death (Item 23a) (Type, Print) Park Drive Ste 214 Argento MD Micholas 14201 31. Date fited (Month, Day, Year)

JUN 0 1 2000 32. Begistrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death BALL Vaa **Physician** Month YETTE 2000 06:20m 5 15 /Medical 4b. City, Town, or Location of Death GLEN BUZNIE 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner ANHE ARUNDEL MILLENNIUM HEALTH& REHAB CENTED 7. Aga (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 5. Social Security Number 6. Sex 5 7 9 - 80 - 3480 1 M 2 F 6. Sex Birthplaca (Stata or Foraign Country) **Funeral** 40 Yrs. WDC APRIL 24 1960 Director Usual Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. tnsida City Limits 28a-f ahow than "natural", or items 23s or 28s-f show WASHINGTON 125Yas 2□No Director D.C 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2015 UNITED STATES 20002 N.E 816 Funeral 11. Marital Status 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. filed within 72 hours after 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas: 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) (Giva kind of work dona during most of working lifa. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SECURITY SECURITY OFFICER 125 Baltimore, Maryland pemil. Pages 1 and 2 should be flie Department of Health and Mental Hy important: If flem 27 Ia marked othn any Injury or other traumatic event once. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be WALTER CAIN CLARA NIX 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
1226, BEN HING Rd. CAPITOL KEIGHTS, Md. 20743 19a. Informant's Name/Ralationship (Type, Print) ANTHONY BALLI HUSBAND 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata CHESAPEAKE CREMATORY 5-20-00 BELTSVILLE, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility 21. Signature of Funaral Sarvice Licenses CAPITOL MORTUARY, INC. 1425 , MARYLAND AVE. arry NE WASH .. DC. 20002 23a. Part1. Enfar the disagre, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** MINUTES TO Immediata Ceusa (Finat disaasa or condition rasulting in death) RESPIRATORY ARREST /Medical HOURZS Examiner Dua to (or as a consequence of): Physician/Medical Examiner ACQUIRED IMMUNE DEFICIENCY SYNDROME YEARS physiclan and s the burial-transit the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): Box 68760. IMMUNODEFICIENCY VIRVS YEARS HUMAN that initiated events rasulting in death) Last Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown bengis the det OPPORTUNISTIC INFECTIONS, MYCOBACTERIUM ANUM Records. þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy INTRACELLULARE. CANDIDA, HERPES INFECTIONS. complation of causa of death? ANEMIA, RECREATIONAL DRUG ABUSE 1 Yas 200 No 1 ☐ Yas 2 ☐ No Vitai toepital or Attending Physician: The hours after death.

\*\*Unerel Director: After this certificate of tilled in by the funeral director, pe 25. Was casa rafarred to medical examinar? 8 26. Place of Death (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Norsing Homa 5 Rasidance 8 Other (Specify) 1 Yas 2 TNo Certification: To of 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of Division 1 (UNatural 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At homa, farm, streef, factory, office building, atc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funerel Completely filled 1 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar ss stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) 16 1 2000 K (Kangarajaw. M.D D0054288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7445 FURNACE BRANCH RD GLEN BURNIE MD 21060 RAMASHAMYI RANGARAJAN. 31. Data filed (Month, Day, Year)
MAY 3 1 2000 32. Registrar's Signatura

**DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygiene 19182 Certificate of Death Rag. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Deeth **Physician** Month MAY 25, MARGARET BALSLEY 2000 1:25 PM /Medical 4a. Facility Nema (If not Institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral**  Birthplaca (State or Foreign Country) Days 1 M 2 X 297-09-0320 88 Yrs. Director APR.14,1912 OHIO Usual Rasidance of Decedant the Maryland 10a. Stata 10h County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD. MONTGOMERY ROCKVILLE Was 2□No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? e filed within 72 hours after death with Il Hygiene. other than "natural", or items 23a or 9701-VEIRS DRIVE 20850 USA Funeral 12. Was Dacedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 M No if Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) Race - American Indian, Biack, Whita, atc. 11. Marital Status 8 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: WHITE þ Specify: 3 X Widowed 4 ☐ Divorced Year or Datas: Be Completed 15. Decedant's Education 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elamantary/Secondary (0-12) Coliage (1-4or 5+) 12 SECRETARY NOT AVAILABLE 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Pages 1 and 2 should be fit tment of Health end Mental H tant. If them 27 is marked off tury or other traumatic ever JOSEPH BROBANDER ELIZABETH WEBER 2 19e. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Heelth er Important: If them 27 is any injury or other trau once. REV.DR.REICHARD-EXECUTOR 9701- VEIRS DRIVE, ROCKVILLE, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1XXuriai 2 Cramation 3 Ramoval from Stata HOPE CEMETERY 5/27/00 SALEM, OHIO 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funeral Service HYSONG CO., INC. 1300- N ST., NW, WASH., DC 23a. Part1. Enter the diseas shock, or heart failure. it ceusad the daath. Do not anter tha moda of dying, such es cardiec or raspiretory errast, in aach lina. Approximata Interval Batween Onset end Daath **Physician** /Medical immediata Cause (Final disaasa or condition rasulting in daath) Examiner or Attending Physician: The law requires that the death certificate be executed buriel-tran Saquantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaase or injury that initiated events rasulting in deeth) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the USB BSU ed by the attending deteched for use es Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 1 Unknown ate has been signed page 2 should be de ρ 24b. Wara autopsy findings evellebia prior to completion of ceuse of death? Completed 24e. Wes en autopsy performad? 1 Yas 2 No 1 □ Yas 2 □ No 25. Was cesa rafarrad to medicel axaminar? Be 26. Place of Death (Check only one) Certification: To 1 Yas 2 No Hospitel: Othar: 4 Vursing Homa 5 Rasidanca 6 Othar (Specify) 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Deta of injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after death. To the Funers! Director; After th completely filled in by the funeral 27. Manner of Deeth 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Naturai 5 Panding invastigation 1 Yes 2 No 2 Accidant 6 Could not be datermined 3 ☐ Suicida 28e. Plece of Injury - At home, ferm, straet, lactory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homloide Certifying Physician: To tha best of my knowledga, death occurred et tha time, dete end place, end due to the cause(s) end menner as steted.

| Certifying Physician: To tha best of my knowledga, death occurred et tha time, dete end place, end due to the cause(s) end menner as steted.

| Medical Examiner: On tha basis of axaminetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. Medicai 29a. Certifier (Check only 29b. Signafure, and title of certifier 29d. Data signed (Month, Day, Year) 29¢ Licansa number 2000 30. Nama and eddrsss of person who completed ceusa of daath (Itam 23a) (Type, Print) KARESH- 9701- VEIRS DR., ROCKVILLE, MD. CHARLES W. 32. Registrer's Signety a 3 0 2000 State

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Month **Physician** May 20, MARRION ANN BARR 2000 6:40 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Hospital Cheverly Prince Georges Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 XF Yrs. Director 577-44-7831 65 03 - 16 - 35Washington DC Usual Residence of Decedent t Oa. State 10b. County t Oc. City, Town or Location t Od. Inside City Limits with the Marylar 1⊠ Yes 2□ No Directo plene.
r than "natural", or thems 23s or 28s-1
the Medical Examinar must be notifie Maryland Prince Georges Capitol Heights 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 20743 USA 3811 Clark Street Funeral t2. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, t t. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. þ Specify: 3 Widowed 4 Divorced Year or Dates: **Black** Completed t6s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Dept of Human Resources Administrative Assistant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths any injury or other traumatic event, phos. t8. Mother's Name (First, Middle, Maiden Sumame) t7. Father's Neme (First, Middle, Last) Be John H. Hall Viola (UnKnown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t9a. Informent's Name/Relationship (Type, Print) 4105 Southern Avenue, Apt# 31, Capitol Heights, MD Estella Johnson / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a: Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removel from Stete Harmony Memorial Park 5-26-00 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) uneral Service Monsee 22. Neme and Address of Facility Strickland Funeral Services, PA 6500 Allentown Rd, Camp Springs, MD 20748 ter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final Ruptured abdominal aortic aneurysm disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Hypertension The law requires that the death certificate be axecuted bunial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and physician the bunel Box 68760 Physician/Medical Due to (or as a consequence of) USB as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Muliti-organ Dysfunction Syndrome Records, þ should be 24e. Was an autopsy performed? 24b. Were eutopsy findings sveileble prior to Completed completion of cause of death? certificate has **page 2** t ☐ Yes 2 ☐ No t Yes 20 No of Vital Physician; funeral director, Be 25. Was cese referred to medical 26. Place of Deeth (Check only one) Hospital: t ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To t ☐ Yes 2 No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Division Attending 5 Pending Investigation 1 Natural t ☐ Yes 2 ☐ No deeth. neral Director: A filled in by the fo 2 Accident 281. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after a 4 Homicide Hospital To the Hospital within 24 hours a To the Funeral C to Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the ceuse(s) end manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month, Day, Year)

MAY 3 0 2000

Server

Wilham Boyce , MD

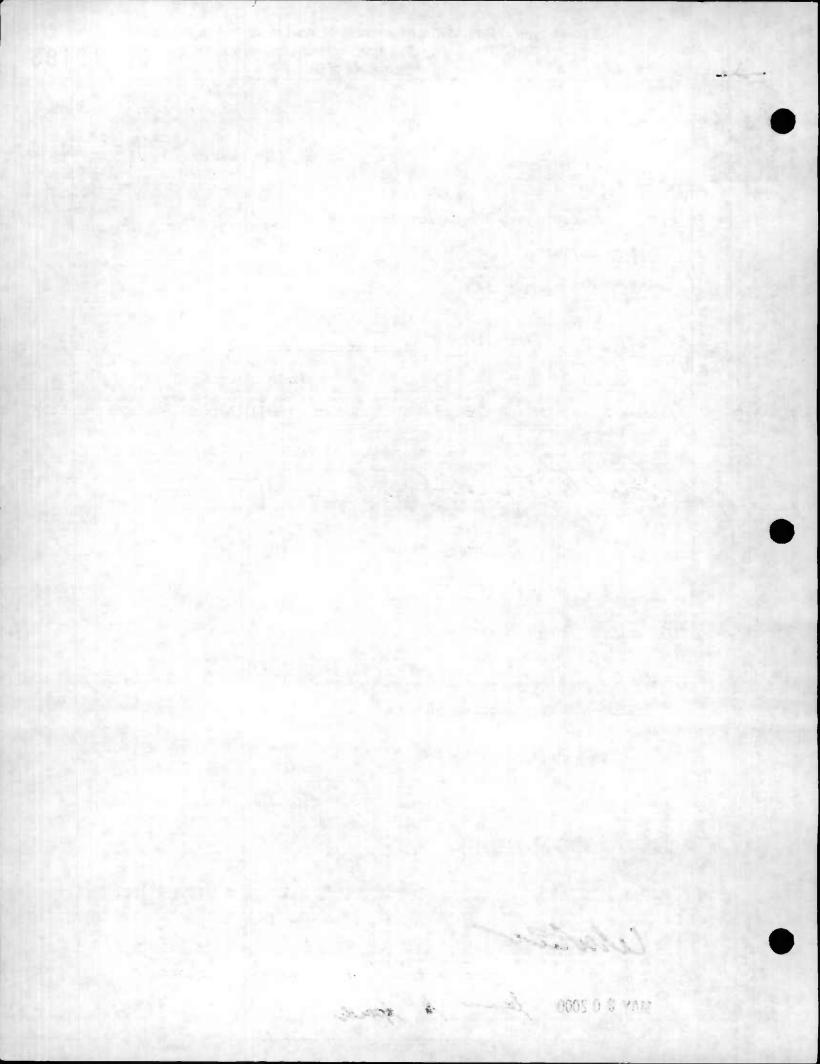
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

trar's Signature.

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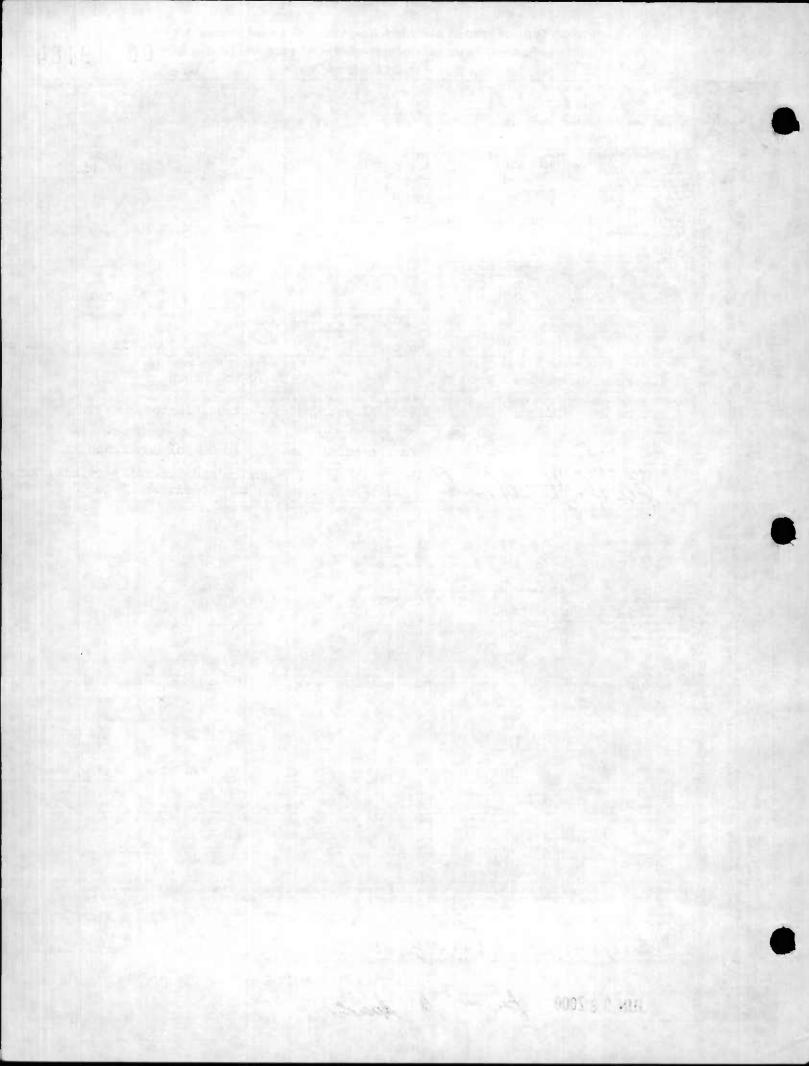
Prince Georges Hospital, Cheverly, Maryland

May 22, 2000



rnest Brown		MS: #23 PART I,	State	of Man	yland / 1 784	Departme Certifica	ent of l	dealth an Death	d Mental Hy	giene	U	19184
		1. Decedent's Name (First, Midd							2. Dete of De	eth	Mana	3. Time of Death
Physic /Medi		ERNEST BROW	N JR.						June	O1 2	Year 2000	04:21 P.M.
Exami		4a Facility Name (If not institution	n, give street and	num <i>ber)</i>				4b. City, Town,	or Location of Deet	,		
			ashingto			Miles	day 1 Vany		ashington	Prince		0
Funeral Director		5. Sociel Security Number 265–35–9404	6. Sex 125 M 2		In yrs. last bi	Yrs. Month	der 1 Year ns Deys		Min. 8. Dete of Bin (Month, Dete of Din 1)	th ly, Year) -58	9. Birthi Cou F1	plece (State or Foreign ntry) orida
2 .	(V)	Usuet Residence of Decedent  10a. State 10b. County	,	10	Oc City Toy	m or Location					1.	10d, fnside City Limits
the Maryle 28s-f sho notified at	ctor	Maryland Princ		11-11		Washing	ton					1 2 Yes 2 □ No
6 9 6	Dire	10e. Street and Number				10f. :	Zip Code		7637	10g. Citizen of	What Cou	ntry?
23 e 23 e	erai	8509 Allentown		December 1	i- 11 C	T 42 Mas Da	2074		7 (Casaibi Van as No	USA 14 Por	a - Amari	can Indien,
Maryland 21215-0020 of 2 should be filed within 72 hours after of th and Mertal Pygere. It is marked other than "natural", or item traumatic event, the Medical Examiner.	by Funeral Director	11. Meritel Stetus  1 □ Never Merried 2 ☑ Mer  3 □ Widowed 4 □ Divorced	ried 1 XY	Decedent Event Forces? es 2 No Give or Detes: 19		1□ Yes	pecify Cub		? (Specify Yes or No uerto Rican, etc.)	Specif	ck, Whita,	
2 hor			nt's Education			. Decedent's U	suel Occu	petion		16b. Kind of B	usiness/In	dustry
215 Med 7	Completed	(Specify only higher Elementery/Secondary (0-12)		ed) pe (1-4or 5+)		life. DO NOT	work done	during most of ed)	working			
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should be file and Mental Hy marked othe amotic event.	To Be	17. Father'a Name (First, Middle, Earnest Br						10-11	Neme (First, Middle sie Lee B		ne)	
and 2 sho ealth and m 27 is ma her traums		19e. Informent's Name/Reletion Debra Brown							Fort Was			
Ores 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion			cemete	of Disposition (for, crematory of Ray Men	or other pla		Dete 6-10-00	20c. Location		
altim nit. Ps samen cotant: Injury 8.		4 Donation 5 Other (S			Del							
Dependent San		Dui D.	Stend	Par	l				Stricklan d, Camp S			rvices, P 20748
Physician /Medical Examiner  physician and the burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
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r Vital Mo ysician: The last is certificate ha director, page	Be C	25. Was case referred to medical						26. Place of	Deeth (Check only	one)		To the second
OT V Physici	To	examiner? Yes 2 No	Hospitel:	i ☐ Inpatient	2 <b>∏</b> ER/0	utpatient 3	DOA		ng Home 5□Res	idenca 6 🗆 Otl	ner (Speci	ity)
Division of Vital Records, P.O. Box 6 to Attanding Physician: The law requires that the death certificate death certificate has been signed by the attending prector: After this certificate has been signed by the attending of his by the funeral director, page 2 should be detached for use as	ation:	Z LI ACCIONITI	igetion	ete of Injury Month, Day Y	(ear) 28b.	Time of Injury M	28c. Inju	uryat ork? ]Yes 2 □ No	28d. Describe	how injury occur	rred	
े विकेट	Sertific	3 ☐ Suicide 6 ☐ Could determ	not be nined 28e. P	leca of Injury uilding, etc. (	- At home, f	erm, street, fec	tory, offica		28f. Location City or To	(Street and Num wn, Stete)	ber or Rui	ral Route Number,
To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical Certification:		Examiner: On th		caminetion e				elece, end due to the occurred at the time			
To the within 2 To the comple	M	29b. Signeture end title of certifier  29c. License number  29d. Date signed (Month, Day, Yes										. Day, Year)
		30. Name end address of person	y Mo completed	VL	th (Item 224)	(Type, Print)	0.0	C.M.E.		June	e 3,	2000
(5)		Stephen Radent		and or wear			Stre	et, Bal	timore, M	arvland	2120	1
St	ate	31. Dete filed (Month, Day, Year		2. Registrer's	Signeture	1		_,				
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 185 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day 2000 Month **Physician** Annie Connor 8:38PM 26, May /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George's If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 F Hours 86 Yrs. Director 241-36-2704 May 6, 1914 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Marylar Name 23a or 28a-f show the Medical Examiner must be notified at MD Prince George's 11X Yes 2 □ No Brentwood Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3904 Perry Street 20722 U.S.A Funeral përmit. Pages 1 and 2 should be filed within 72 hours after deal legopartment of Health and Mental Hygiene. Important if flem 27 is marked other en. any injury or other traumment. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Biack, White, etc. 11. Marital Status 1 Never Married 2 Married Black 1 ☐ Yes 2 XNo Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) Clerk 12 Government. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Caleb Williamson Octavia Shuford 2 19a. Informant's Name/Retationship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Charles Williamson-son 4310 30th Street Mt. Rainer MD 20712 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 6-2-00 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover RD Landover MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each tine. Approximate Intervat Between Onset and Death Physician /Medical Immediate Cause (Final 480 disease or condition resulting in death) Lxaminer Examiner allor Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and of in by the tuneral director, page 2 should be detached for use as the burla-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No Completed by androvaseulor 24b. Ware autopsy findings available prior to 24a. Wes an eutopsy performed? completion of cause of death? his 0 2 No 1 Tes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 5 Panding investigation Division 1 Natural 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral Dicompletely filled in edicai 29a. Certifier 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner es stated (Check only one) 2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 48213 5-28-2000. le. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mitchelline Rd # 220 Burie MD 20716

State Registrar

JUN 0 2 2000 **DHMH 16 Rev 6/95** 

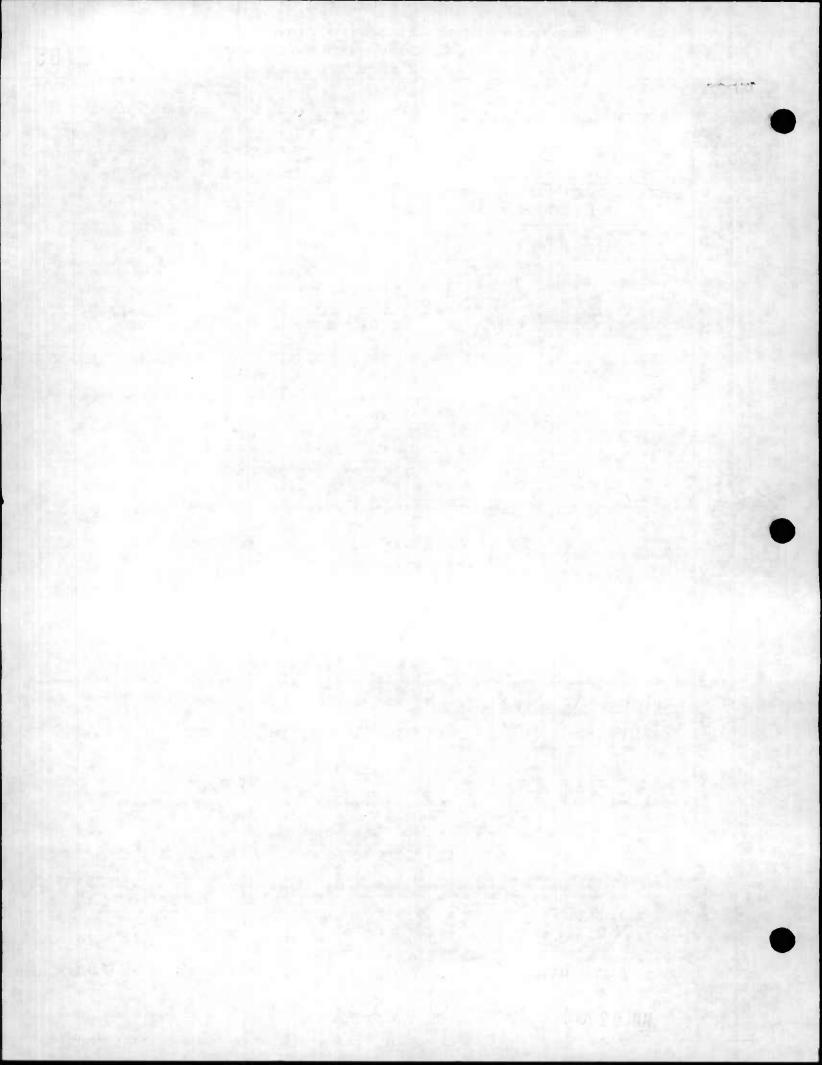
32. Registrar's Signature

4000

Ashai

lam 31. Date filed (Month, Day, Year)

**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth DOPER Month **Physician** June 1, 12:17 PM /Medical 4b. City, Town, or Location of Deeth 4a. Facility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** Pineview Nursing & Rehab Center Prince Georges Clinton If Under 1 Yeer | if Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Sept.17,1921 9. Birthpiace (State or Foreign Country) New York **Funeral** Months Hours 1⊠M 2□F 78 Director 111-01-6952 Usuel Residence of Dacedant with the Maryland 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Speartment of Haaith and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinas must be nothed as 10d. Inside City Limits Maryland 1 ☐ Yes 2 No Funeral Director Prince Georges Oxon Hill 10e Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1525 Dunwoody Avenue 20745 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 ☑ Yes 2 ☐ No WWII If Yes, Give Yeer or Detes: 1 Never Married 2 Married Raltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Federal Government Elementery/Secondery (0-12) College (1-4or 5+) Supervisor Dept. of Energy 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Unknown Cooper P Bertha Harry 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meliing Address (Street end Number or Rurei Route Number, City or Town, State, Zip Code) Alan F. Cooper/Son 719 Hatfield Ct., Waldorf, MD 20602 20e, Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete MXBuriei 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Othar (Specify) Arlington National Cemetery 6/13/2000 Arlington, VA rvice Licens 21. Signeture of Funera 22. Neme end Address of Fecility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete interval Batwaan Onsat and Death Physician Immediata Ceuse (Final diseese or condition rasulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseesa or Injury thet initieted events resulting in deeth) Lest for usa as the burial-tran Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown þ page 2 should be 24b. Were eutopsy findings eveileble prior to completion of cause of daath? Be Completed 24e. Wes en eutopsy performed? peen Aftar this certificate has 1 ☐ Yes ŽÃ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

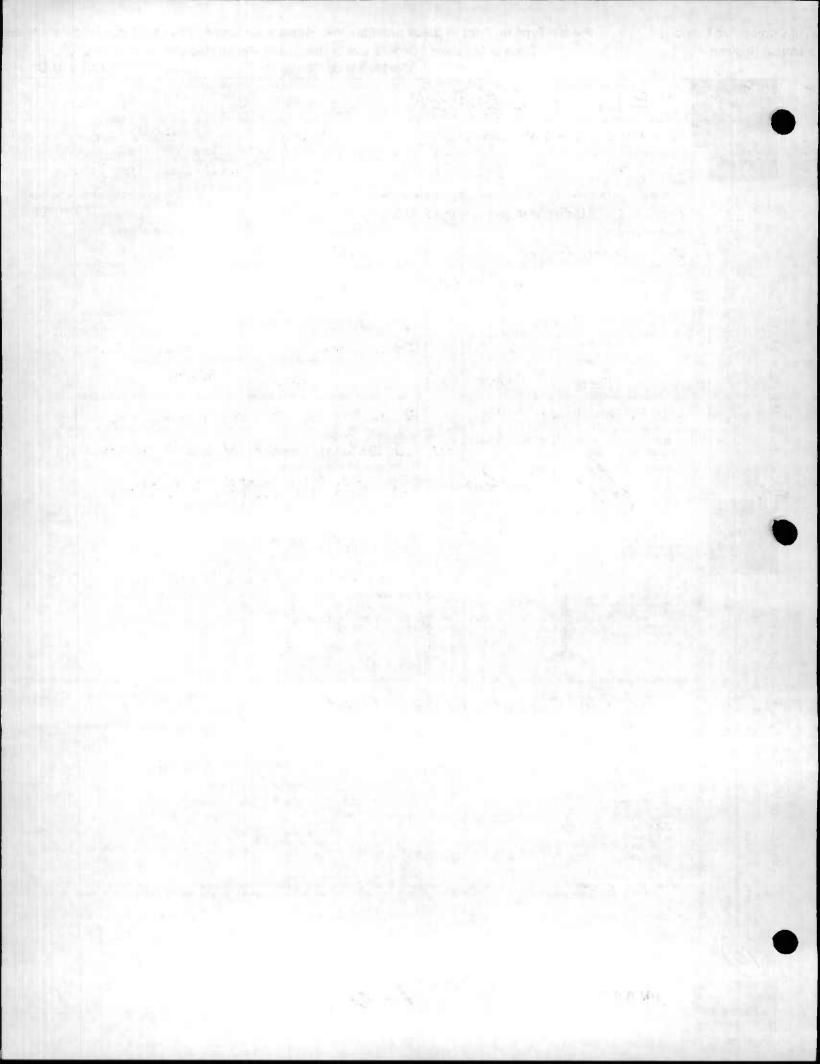
To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case referred to medical 26. Plece of Deeth (Check only ona) examiner' Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Spacify) Certification: To 1 ☐ Yas 2 No 27. Manner of Death 28c. Injury et Work? 28a. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 1XXVeturel 5 Pending investigation 1 Yes 2 🗆 No 2 Accident 6 Could not be determined 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Piece of injury - At home, ferm, streat, factory, office building, etc. (Specify) 4 | Homicide \*\*Excertifying Physician: To the best of my knowledge, deeth occurred et tha time, date and pleca, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a, Certifier Medical 29b. Signeture end title of certifier 29d. Date signed (Month, Dey, Year) rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

Registrar

State



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 9 1 8 7

			State of Marylar		Certificat				og. No.	15	101	
		1. Decedent's Name (First, Middle, Last	)	-				2. Date of Dear	h	V	3. Tima of De	ath
1	Physician /Medical	John Castal	do					Month May 29		Year	7:30 F	M
	Examiner	4a Fscility Name (If not institution, give	street and number)			4	b. City, Town, or	Location of Death	4c. County o			
		3003 Annabelle	Place				Bowie		Princ	e Ge	orges	
	Funeral	Social Security Number     6. Se	SM OFF		Months		If Under 24 Hrs Hours Min.	(Month, Day	Year)	9. Birthpla Countr	ce (State or Fo	preign
	Director	053-05-3211	85	,	rs.			June27	,1914	New	York	
	P 8	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town	or Location					10	d. Inside City L	Limits
	Many A sehi	Md. Prince G	eorges		Bo.	wie					1 2 Yes 2	□No
	with the Marylan e or 28e-f show be notified at Director	10e. Street and Number	eorges		101. Zip			1	0g. Citizen of W	/hat Count	y?	
	23a o unit be	3003 Annabelle	Dlace			207	16		USA			
	r harre 23 siner must Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J,S.				Specify Yes or No- to Rican, etc.)	14. Race	- America c, White, et		177
0	or the	1 Never Married 2 Married	1 X Yes 2 □ No 19	41-	1  Yes			to rucari, etc.;	Specify:		ic.	
Maryland 21215-0020	D E. S	3 ☑ Widowed 4 □ Divorced	Year or Dates: 19	46	12.00		opeony.			Whi		
Th.		15. Decedent's Edu (Specify only highest grad	ication le co <i>mpleted)</i>	16a.	Decedent's Usua (Give kind of wo lifa, DO NOT us	rk done	during most of wo	rking	16b. Kind of Bus	siness/Indu	istry	
12	within then the Me	Elemantary/Secondary (0-12)	College (1-4or 5+)	a.			"					
9		17. Father's Name (First, Middle, Last)		Silc	p Fore	man	18. Mother's Na	me (First, Middle, i	Airlin Maiden Sumame			
an	id be fill be	Desimilation Control of the Control	taldo				Rosa	DiPalo		,		
Ž	T Test	19a. tnformant's Name/Relationship (T)		19b.	Mailing Address	(Street		ural Route Number		Stata, Zip (	Code)	
ž	27 15 grant 1	Joyce Culley		3.0	03 Ann	ahe	lle Pla	ce Bowi	e Md	207	16	
e,	A Head	20a. Method of Disposition	20b.	Place of	Disposition (Nar	na of	<sup>28)</sup> 05–30	Data	20c. Location - 0			
ê	Page ent o nt: iff ry or	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	ror	olitan	Cr	ematory	7 00	lexand	lria.	Va	
Baltimore,	Series Series	21 Signature of Funeral Service Licens	99	19	22. Name an		ss of Facility					
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1		23a. Part1. Enter the disease, or comp shock, or haart failure. List only o									Approximate	
	Physicián	shock, or haart failure. List only o	ne cause on each lina.								Intarval Batwee Onset and Dea	
	/Medical	Immediate Cause (Final disaasa or condition	Luna	C	ance	-				3	480	MC
-	Examiner	resulting in death)	•	or as a c	onsequenca of):		N. Marie			1.	0	1
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	tificate be executed g physician and as the bunal-trensit	Sequentially list conditions,	Due to (	or as a c	onsequenca of):		72					
68760,	be est	Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause (Disease or Injury	С									
287	icate be physicie is the bu	that initiated evants resulting in death) Last	Due to (	or as a c	onsequenca of):					1		
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o.	y the sched	Part II. Other algnificant conditions co	ntributing to death but not re-	sulting in	the underlying o	ause giv	en in Part I.		obacco uss con sa 2□ No	3 Prob		
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n of	After this funeral d	27. Mannar of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. T	ima of 2	28c. Injur Wor	y at k?	28d. Dascribe h	ow injury occurre	ad		
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	To the Hospi within 24 hou To the Funei completely fil	one)  29b. Signature and title of certifier	and mannar stated.		29	s. Licens	e number		9d. Date signed	(Month, E	Pay, Year)	
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	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	atura		112	not.	uwie	1-11		110	
I	Registrar	11 D 1 2000	Geneva	A	· La							

State of Maryland / Department of Health and Mental Hygiene

Amended Item#12 perFHG785 7/25/2000 EW Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** 6:15 PM Harold W. Carson May 29, /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, ) 5/17/17 9. Birthplece (State or Foreign Country) N. Carolina 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) **Funeral** Days 228-16-6618 83 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow ed other than "natural", or itema 23a or 28a-f ahor event, the Medical Examinar must be notified at 1 □XYes 2 □ No Director D.C. N/A Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5439 B St., S.E. 20019 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1∑QYes 2 □ No If Yes, Give Year or Dates: 43—44 14. Race - American Indian, Black, White, atc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status pernit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelih and Mental Hyglene. Important: If item 27 is marked other than "natural", or item eny injury or other traumatic event, the Medical Exeminations. 1 Never Married 20 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black ò 3 ☐ Widowed 4 ☐ Divorced 43-46 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 9th College (1-4or 5+) Leader-Painter D.C. Government 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middle, Last) Be Lum Carson Ada Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary E. Carson/Wife 5439 B St., S.E., Washington, D.C. 20019 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete \* Burial 2 ☐ Cremetion 3 ☐ Removal from State 6/5/00 Ft. Lincoln Cem. Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Wash., D.C. 20019 21. Signature of Funeral Service Licensee W 1 att 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvel Batween Onset and Deeth **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical · Antonios vepotre Chridioussulan Disease Examiner Due to (or es a consequence of): Examiner buriel-transit requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physicien Physician/Medical Due to (or as a consequence of): use es the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by to should be detach 1 Yes 2 No 3 Probably 4 Unknown Respiratory Failure, Peninheral Vaswiar Records, þ 24b. Were autopsy findings eveilable prior to completion of causa of death? Completed 24a. Wes an eutopsy performed? astrointestinal tract The lew hemornhage 1 Yas 2 No 1 Yes 2 No certificate Sensis Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case refarred to medical B 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and mannar es stated. 29e. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eanlworehor may 30, 2000 DO1852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. DEVORE MD 4203 QUEENSbury Rd HYATSVIlle MD 20781 31. Date filed (Month, Day, Year) MAY 3 1 2000 32. Registrar's Signature State Registrar

1005 8 YAY

3. Time of Death

10d. fnslde City Limits

1 N Vac 2 No

Day 2 4, 2 400 14:34 4c. County of Death

14. Race - American Indian, Bleck, White, etc.

Prince George's If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Arkansas

10b. County

Cheverly

Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zlp Code U.S.A.

5719 Lockwood Road 20785 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married

1 ☐ Yes 2 No Specify: Specify: White 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) National Security Elementary/Secondary (0-12) College (1-4or 5+) Intelligence Analyst Agency 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last)

William Patrick Bessie Dale

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)

Catherine C. Abbott - Granddaughter 5719 Lockwood Road, Cheverly, Maryland 20a. Method of Disposition 20c. Location - City or Town, State

20b. Piace of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 6/01/2000 Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify)

22. Name end Address of Facility
Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD MAC 20781

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death

Assiration Preumonia. Immediate Ceuse (Final . Dehydration diseese or condition resulting in death) mpaired oral Intake + Impaired Gug

ar

Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.

Breast Carcinoma,

23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown

24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 TYes 25 No

25. Was case referred to medical 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred

28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier (Check only one) 1 ☐ Certifying Physicfan: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) end menner as stated.
2 ☐ Medicat Examiner: On the bests of examination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai completely To the To the To the I 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number D31001 cause of death (Item 23a) (Type, Print) 7500 5-eenway Catr. Dr. #43 0 Greenbelt, MD. Kewitz, M.D 2. Registrar's Signatur State Registrar

item 27 le marked other than "natural", or items 23s or 28s-1 show other treumstic event, the Medical Examiner must be notified at deeth with pernit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or thei any Injury or other treumatic event. In stant of the stant 3altimore, Maryland 21215-0020

Directo

Funeral

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Completed

Be

Examiner

Physician/Medical

Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In deeth) Last

4 Homicide

3 ₩ Widowed 4 Divorced

**Physician** /Medical Examiner

requires that the death certificate be executed burial-tran and the signed by t d be detact

certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director; After this certifica

Division of Vital Records, P.O. Box 68760,

Designation and Replanted Prevention I wife Texture 1.0 Secretary of the 2017 Character the war was a cool of the same

Certification: spital or Attenditions after death. Hospital To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician. To the bust of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

27 Medical Examiner: On the busis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifing O.C.M.E. June 02, 2000

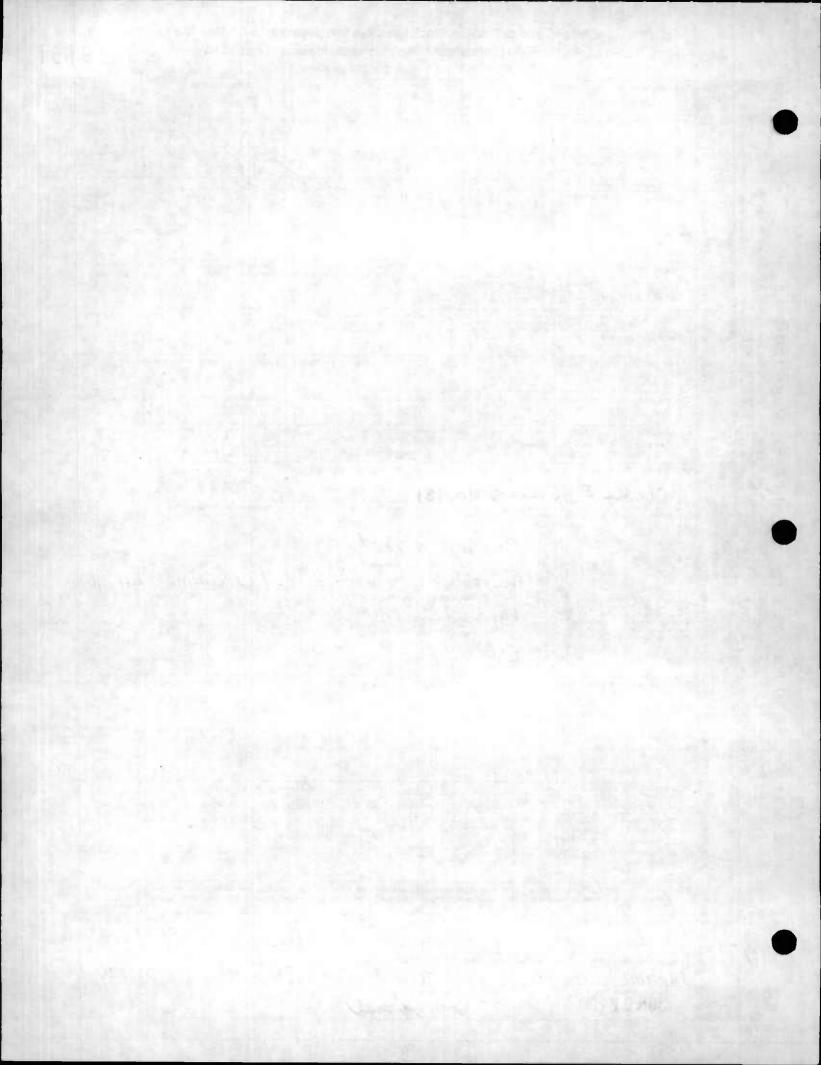
30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) forler

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) JUN 0 6 2000 3. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 00 19191.

						, unou		Death			Reg. No.			
ician	1. Decedent's Name (First, Mic	- 1-7								2. Data of D Month	Day	Y	ear	3. Time of Death
lical	ALFRED MAUR										8,200			8:00pm
er	4a Facility Name (If not instituted PARKWAY	ST.						CHE	VERI		PR	INCE	GEOR	RGES
	5. Sociel Security Number 578–58–6543	6. Se	X M 2□ F	7. Age (In y	rs. last birthday Yrs.	Months	Deys	If Under Hours	Min.	8. Dete of B (Month, D AUGUS	irth Pay, Year) T 21,		Country) WAS	e (State or Forei
ō	Usuet Residence of Decedent  10a. State 10b. County 10c. City, Town or Location							•		10d.	Insida City Limi			
Director	10e. Street and Number		EORGES	C	HEVERLY	10f. Zi	p Code						et Country	
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10 00 0	17. Fathar's Neme (First, Midd ROBERT DIGGS									e (First, Middle LOWRY		Gumama)	78	
	19e. Informant's Neme/Relation JOAN DIGGS /									RVERLY,			ate, Zip Co	ode)
	20e Method of Disposition  20e Method of Disposition  20e Method of Disposition  4 Donetion 5 Other			Stele	D. Place of Disp cemetery, cre WASHING	ematory or	othar plac		1	Date 5-2-00		ation - Cit	ty or Town,	, Stata
	23e. Part1. Enter the diseese, shock, or heart taiture. L	ist only o	ne cause on	each line.									tnt	proximete tervat Between nset and Daath
	Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initied events resulting in death) Lest	{	a. <u>Ca</u> b. <u>Mu</u> c. <u>Hu</u> d. <u>O</u>	Due to Due to	c arr o (or es a conse white " o (or as e conse hensi o (or as e conse	raws equence of)	110		ell	Carui		J.le		
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o Be Completed by Physician	disease or condition resulting In death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest  Part It. Other eignificant conditions axaminer?  1 Yes 2 No  27. Manny of Death 1 Natural S Pen Accident 3 Suicide 6 Coudelt Get Cause Per Service Pen Cause Pen Pen Pen Pen Pen Pen Pen Pen Pen Pe	ding stigation to not be semined	b. Mu c. Hospital:    28a. Date (More 28e. Place pull)	Due to  Due to  Per  Due to  D	o (or as a consection of the c	equence of)  requence of)  requence of)  underlying of M  threet, fector	Cause giv	26. Place rer: 4 No. No. No. No. No. No. No. No. No. No.	e of Deat	23b. Did 24e. Wa per  1 Check only 28d. Describe 28f. Location City or To	Itobacco u  Yes 25 s an eutops formed?  Yas 25 sidence 6 s how injury (Street and own, State) e cause(s) a	No 3 Sy 2 No Other occurred	ibute to the Probab  24b. Wera availa comploid des 1 Y (Specify)	autopsy finding ble prior to letton of cause attn. Yes 2 No



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9192. Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Covera Davis May 30, 2000 17:50 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year 7. Aga (In yrs. last birthday) 65 yrs. If Under 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 25℃F 577-44-3879 September 20. 1934 North Carolina Usuai Residanca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Capital Heights to Yas 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 United States of America 515 Capital Heights Blvd. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4XXDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) College (1-4or 5+) National Education Assoc. 12th grade Accounting 17. Fethar's Name (First, Middla, Last) Hence Baskett 18. Mother's Nama (First, Middle, Maiden Sumame) Hattie L. Shearin 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mrs. Melva D. Collins (Daughter) 2209 Sandalwood Drive Waldorf, Maryland 20601 20b. Plece of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stata ₽ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata National Harmony Memorial Park 6/3/2000 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licansee 22 Name and Address of Facility HME, INC. 4339 HINT PLACE, N.E. WASHINGTON, D.C. 20019 when the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Causa (Final disaasa or condition resulting in daath) Cardino areal L.T. Corony asly Lises Dua to (or as a consequence of): Due to (or as a consequence of): in sulin deput Dulles madi Dua to (or as a consequence of): Hypetasi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No Prephend someth

**Physician** /Medical Examiner

physician and s the burial-transit

been signed by should be detact

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in by

To the Hospital of water 24 hours aff To the Funeral Di completely filled in

edical Certification: To

certificate

I or Attanding Physician; after death.
Director: After this certifica

The law requires that the death certificate be executed

Box 68760.

P.O. 1

Records.

Division of Vital

**Physician** 

/Medical

Examiner

Director

Funeral

Be

**Funeral** 

Director

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poemit. Pages 1 and 2 should be filed within 72 hours after Opportment of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or its any injury or other traumstic event, the Medical Examinos once.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if any, laading to immediata causa. Enter Undarfying Causa (Disease or Injury that initiated events rasulting in death) Last þ Be Completed

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No

1 ☐ Yas 2 ☑ No

26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 1 Certifying Phyeician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

1 Yes 2 No

29b. Signatura and titla of certifier

5 Panding invastigation

6 Could not be datarmined

D 25640

29c. License number

28c. tnjury at Work?

29d. Data signed (Month, Day, Year) 06.01.00

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)
Khosrow Davachi, M.D. 7801 Old Branch Avenue Suite #409 Clinton, Maryland 20743

112 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

State Registrar

31. Date filed (Month, Day, Year) JUN 0 2 2000

25. Was casa rafarred to medical

1 Yas 2 No

27. Mannar of Death

1 Natural

2 Accident

3 Suicida

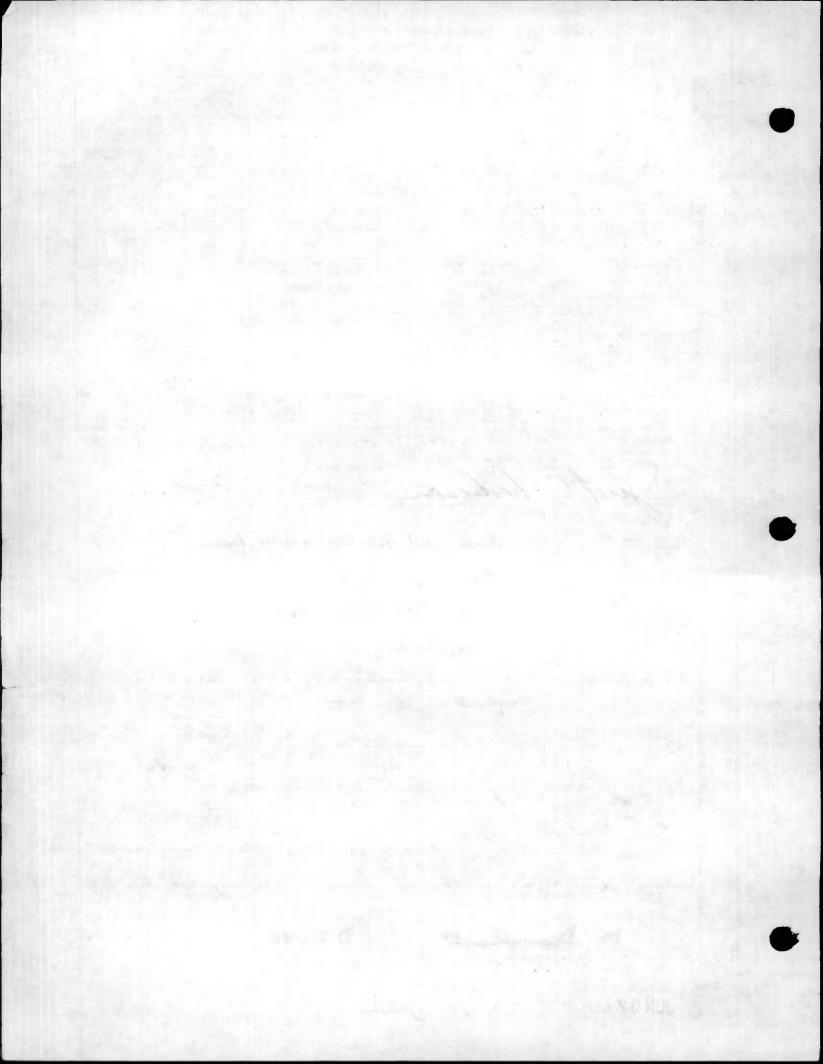
29a. Cartifiar (Check only one)

4 Homicide

Hospital:

28a. Data of Injury (Month, Day Year)

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

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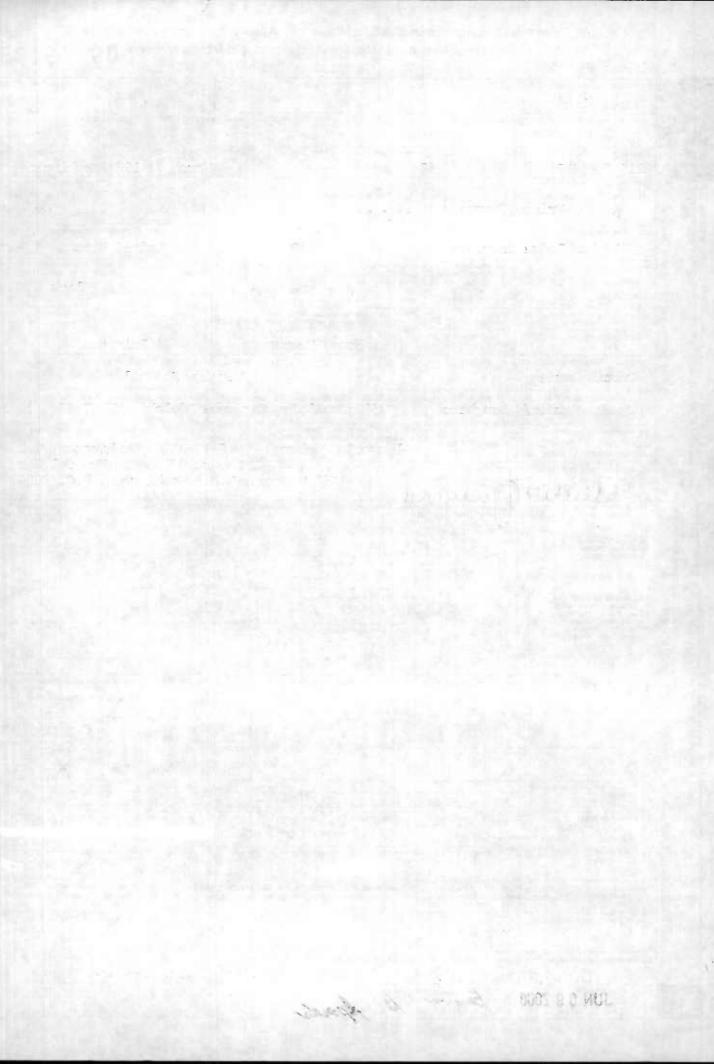
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	2 should be filed within 72 hours effer death with the Maryland and Mental Hygiene. Is merked other than "natural", or items 23s or 28s-f show aumatic event, the Medical Examinat must be notified at To Be Completed by Funeral Director	10e. Street and Nu		olcroft La	ane	10t.	Zip Code 2	0774		10g. Citizen of V	ed Sta	
	dea Ga	11. Marital Status		12. Was Deceden	t Evar in U.S.	13. Was De	cedent of	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No	o- 14. Rac	e - American	
Maryland 21215-0020	natural, or its	1 Never Man	riad 2 Married	Armed Forces  1 Yes 2 If Yes, Give Year or Dates	XNo		2 TyNo		to Hican, etc.)	Specify	k, White, etc	
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7	Co training			4+			leach				rnment	
Pu	tal H d oth	17. Father's Name	(First, Middle, Last	)				18. Mother's Na	me (First, Middle	, Maiden Suman	a)	
19	Ment Ment arked arked	Jame	es P. Joh	nson				I I	lajorie	Delmar		
and a	ges 1 and 2 should be filed within 72 ho to Health and Mental Hygiene. If item 27 is merked other than "natur or other traumatic event, the Medical To Be Completed	19a. Informant's N	lame/Relationship	Type, Print)	19	b. Mailing Addr	ess (Stree	t and Number or R	ural Route Numb	per, City or Town,	State, Zip Co	ode)
Σ		Jacque	es Diggs	- Son		3405 E	Caste	rn Ave.,	Mt. Rai	nier, MI	2071	2-2150
a)	permit. Pages 1 end: Department of Health Important: If item 27 i any Injury or other tr. 2068.	20a. Method of Dis			20b. Place	of Disposition (i			Date	20c. Location -		
ō	in it is	1 Burial 2	Cremetion 3	Removal from State	Θ							
Ë	Part:	4 Donetion	5 Other (Special	fy)	Mea	dows Ce		3	31/200		Bern,	NC
Baltimore,	permit. Pages 1 Department of F Important: If its any Injury or or	21. Signatura of F	neral Service Lice	1990 A	-	22. Name	and Addr	ess of Facility	Stewart	Funeral	Home	
Ш	20119	1 ml	DALTS	Xam. V	111	40	001 B	enning Ro	l., N.E.	Wash.,	D.C.	20019
20		23a. Part1/Enter	the disease or con	polications that cause	ed the deeth. Do	not enter the n	node of dv	ing, such as cardia	c or raspiratory a	arrast.	. At	oproximata
d		shock or he	art feilure. List only	plications that cause one cause on each	line.		,				In	oproximata tervel Between nset and Death
6	Physician			144	- ( (	A .						
4	/Medical Examiner	Immediate Cause disease or condition	on	· Mictal	statez	cancer	^					
п		resulting in deeth)		G	Due to (or es a	consequenca	of):					
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner	Coguantially list of	andhina C	b. ————	Due to (or as a	consequence	of):					24
~	exec n an iel-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										11
68760,	be sicia	Cause (Disease of	r injury	C							+	
87	phys the	resulting in death)	Last		Dua to (or as a	consequence	of):					
	ing e es			d								
Box	v requires that the death cert been signed by the attending should be detached for use leted by Physician/M		1	u								
	dead dead se at se	Part II. Other signi	ificant conditions	contributing to death	but not resulting	In the underlyin	g cause g	ven in Part I.	23b. Dld	tobacco use co	ntributa to th	e causa of death?
P.0	by the	hardens !	ala CU	MIGA. Ja					10	Yes 2 No	3 Probab	y 4 Onknown
	that the det	hydrola()4	AHE CU	Mer to	peritone	·um						
Records,	The law requires the lass been signed page 2 should be d	4		thrombo					24a Was	s an autopsy	24b. Were	autopsy findings
Ö	requirements	Decla	venous	Throm40	515				perf	ormed?	availa	ible prior to letion of causa
ec	law law as b	4.	1								of dea	ath?
8	The page	Thron	rnord tobe	414					10	Yes 20 No	1 🗆 Y	as 2□ No
Division of Vital	ystclen: The lav is certificate has director, page 2	25. Was casa rafe	rred to medical					26 Place of De	ath (Chack only	one)	1	
5		exeminer?	/	Hospitel:	tient 2 ER/C	hitentient 2	DOA O	han		idenca 6 Oth	or (Consilu)	
of	this of all dire.	27. Manner of Dea				Time of			T	how Injury occur		
5	ing I	1 Netural	5 Pending	28a. Date of In (Month, D	ay Year)	Injury	28c. Inju		200. 0030100	mon injuly coods	100	
Sic	tal or Attending P is after death. al Director: After t led in by the funers Certification:	2 Accident	investigatio			M	1	Yes 2 No				
5	Py Dy Liff	3 Suicide	6 Could not be determined	289. Place of I	njury - At home, f	larm, street, fac	tory, office		281. Location City or To	(Street and Numi	per or Rural R	loute Number,
Ö	d in diplomation			outg,	(0)							
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (	29a. Certifier	1 Certifying Pr	ysician: To the bes	t of my knowledg	e, death occurr	ed at the t	ime, dete end plac	e, end due to the	cause(s) end m	anner as state	ed.
	he Hospi in 24 hou he Funer pletely fill edical	(Check only one)		miner: On the basis and manner:	of exemination a							
	Me Me	29b. Signature and	d title of cartifier				29c. Licen	se number		29d. Data signe	d (Month, Da	v. Year)
	5.½ t.8	Loc. Orginatory and								3/23	1200	D
	(0)	100	wy	10 10 20			DOO	43662				
	(X)	30. Name and add	lress of person who	completed cause of	death (Item 23a)	(Type, Print)						
	(-)	11-11/1AW	1 Rours	Pa Hoch	3001 F	toop DVI	ve,	Cheverly	ms wi	181		
		I IVI AMENTA	1 100410	11 4 7	- 01 1							
	State	31. Date filed (Moi	nth, Dey, Yaar)	32. Regis	trar's Signature							
	State Registrar	31. Date filed (Mon	nth. Dey, Yaar) 7 3 0 2000	32. Regis	strar's Signature	1		Cherry				

riease	type of Print in black indelible link. Assure All Copies Are L	egible.	
	State of Maryland / Department of Health and Mental Hygiene	00	191

	#23 PART I, 27		ER MEX	Cer	tificate	of L	Death			Reg. No			2120
ician	edent's Name (First, Middle, La								2. Date of D Month	Ds		Year	3. Time of Death
dical	wendolyn Da cility Name (If not institution, give	arden e street end number)	)			41	b. City. To	wn, or L	June ocation of Dea	05 th 4c	. County o	000 of Death	11:00 P.M
miler	ince George's 1				*			verl				Geoi	cae's
	al Security Number 6. S		ge (In yrs. la		If Under 1		If Under	24 Hrs.					ace (Stete or Foreign
24	5-98-9423	□M 20 F	43	Yrs.	Months I	Days	Hours	Min.	March	7, 1	957	Washi	ington, D.
Usual 1	Residence of Decedent tate 10b. County		10c City	Town or Lo	eation							10	Od. Inside City Limits
_		George's		elphi									¥XYes 2□No
10e. S	treet and Number		AU	етрит	10f. Zip C	ode				10g. Cit	izen of W	hat Count	try?
2	512 BuckLodge !	Terrence			207	83							of Ameri
-	rital Status	12. Was Decedent Armed Forces?		. 13. V	Vas Deceder	nt of His	spanic Or	igin? (Sp	ecify Yes or N Rican, etc.)	lo-		- America	
	Xivever Married 2 ☐ Merried Widowed 4 ☐ Divorced	1 Yes 35 If Yes, Give Year or Dates:			Yes 2		Specify:		riloan, etc.)			Blac	
	15. Decedent's Ed (Specify only highest gra	ducation		16a. Deced	ent's Usual ( kind of work	Occupa done d	ation	t of work	ina	16b. K	ind of Bus	siness/Ind	ustry
Elen	nentary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use	retired)	)	it Of WORK	"ig	_			
				H	ouse K	eep			- William Addition		ivate		
	ther's Name (First, Middle, Last, urtis Darden						18. Moth		e (First, Middl nice St			9)	
	nformant's Name/Relationship ( ymeka Darden/	Type, Print) Daughter							al Route Num ce Adel				
	ethod of Disposition		CO	ce of Dispo	sition (Neme	of er pleci	e)		Date	20c. L	ocation - (	City or To	wn, State
	XBurial 2 ☐ Cremation 3 ☐ ☐ Donation 5 ☐ Other (Specif			enwood	d Ceme	ter	У		-10-200				n, D.C.
21. Sig	Glenda IM. Fr	eman	na		1353	H S	treet	: N.1	E. Was	shing			al Service 20002
Immed	Pert1. Efter the disease, or com shock, by heart failure. List only diate Cause (Final se or condition on in death)	RESPIRA	ATORY  Due to (or	DISTRI ANES	ESS CO THESIA uenca of):	MPL	ICAT	ING	INDUCT		F		Approximate Interval Between Onset and Death
Seque	entially list conditions,	b		as a conseq	OF SK	Filifi	TAL	RAC	TURES			1	
cause	ntially list conditions, leading to immediate Enter Underlying	MOTOR V	/EHICI	E ACC	IDENT								
Cause (Disease or injury that initiated events resulting in death) Last  Due to (or es a consequence of):													
Part II.	Other significant conditions o	ontributing to death b	out not resul	ting in the ur	nderlying cau	se give	en in Part	l.	23b. DI	d tobacco	uae con	tribute to	the cause of death?
									10	Yes 2	Kno	3 Prob	ably 4 Unknow
			r u		1					s an auto formed?	psy	ava	re autopsy findings liable prior to appletion of cause death?
									15	Yes 2	□No	1	Yes 2 No
25. W	is case referred to medical						26. Plac	e of Deal	h (Check only	1			
ext	aminer? ] Yes 2 No	Hospitai:	ent 2 E	R/Outpatien	3 DOA	Othe	AF:		ome 5 Re		6 □Othe	r (Specify	)
1_0	nner of Death  Natural 5 Pending  Accident investigation	28a. Date of Inju (Month, De		28b. Time of Injury 5:41		: Injury Work				e how inju	ry occurr	ed PAS	SENGER IN
	Suicide 6 Could not b Homicide determined	e 28e. Place of Injuding, et	jury - At hor tc. (Specify)	ne, farm, str	et, factory, o	office			28f. Location City or 7 202)	(Street a own, Stat CHEV	PAN ERLY	DOVEF MD	Route Number RD. (RT.
		yelcian: To the best niner; On the basis o and manner st	f examination	ledge, death	occurred al				and due to th	e cause(s	) and mai	nner as st	ated.
	igneture end litle of certifier	1M. 2	1	-			number .M.E					2000	Day, Year)
20.11	me and eddress of person with	completed cause of c	deeth (Item :	23a) (Type,	Print)								

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Data of Death

30.

2000

4c. County of Deeth

MONTGOMERY

USA

RETAIL

14. Rece - American Indian Bieck, Whita, atc.

Specify: WHITE

Month

MAY

4b. City, Town, or Location of Daath

3. Tima of Death

3:35 PM

10d. Insida City Limits

Approximeta Intarval Batween Onset and Death

1 XYas 2 No

9. Birthplece (Stata or Foraign

OHTO

Division of Vital Records, P.O. Box 68760, after death Director: /

Baltimore, Maryland 21215-0020

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Wara autopsy findings evailable prior to complation of cause of death? 24a. Was an autopsy parformed? 1 Yas 2 No 1 Yes 2 No Be 25. Was casa rafarred to medical examinar? 26. Placa of Death (Check only ona) 2 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding invastigation 1 Yas 2 No 2 Accidant 3 Suicide 6 Could not be 28a. Placa of injury - At homa, farm, street, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida Certifying Physician: To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the causa(s) end mannar steted. Medical 29a. Cartifian (Check only one)

29c. Licanse number

To the Hospital within 24 hours a To the Funeral C

State Registrar

29b. Signature and titla of certifian

1. Decedant's Nama (First, Middla, Last)

WILLIAM

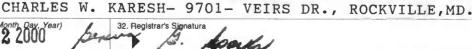
4e. Fecility Nama (If not institution, giva straat and number)

FUZI

**Physician** 

/Medical

**Examiner** 



30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

DHMH 16 Rev 6/95

After this

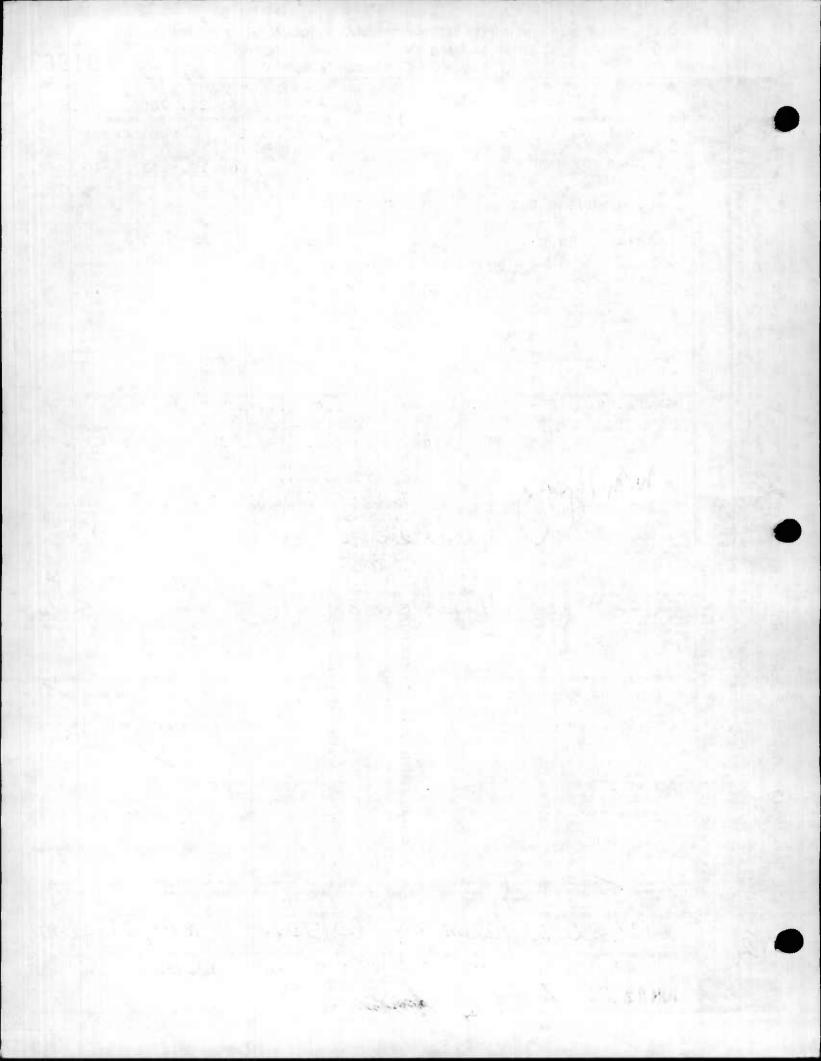
Willed in by

Attending

Hospital

death

29d. Dete signad (Month, Day, Year)



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend \$ 8.Per Fam. PGC 6-6-2000 cr 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Death May 30, 2:25PM 2000 Franklin 4a Facility Neme (Il not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Prince George's Bradford Oaks Nursing&Rehabilitation Center Clinton 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. Ver Months Deys Hours Min. 8. Dete of Birth (Month, Day Dec. 30 Birthplece (State or Foreign Country) 1₩ 2□ F Alabama Dec. 74 421-30-8615 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Prince George's Fort Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9510 Fort Foote Road 20744 Funeral 14. Raca - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Specify: White 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Office of Sec. of Defense Budget Analyst 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Mary Kate Blue Shepherd R. Franklin 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mary Grantham Franklin/Wife Same as item 10 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1XXBuriel 2 Cremetion 3 Removel from State Peninsula Memorial Gardens 6/3/2000 Newport News, VA. 4 ☐ Donetion 5 ☐ Other (Specify) Ceorge P. Kalas Funeral Home, P.A. 21, Signature of unerel Service Licenses alon 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 er the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, heart teilure. List only one cause an each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Final UMONIA diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequenca ot): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 25 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

attending physician for use es the buris

signed by the a

page 2 should be

The lew requires that the deeth certificate be executed

or Attending Physician:

To the Hospital or Attending Physical 24 hours after deeth.
To the Funeral Director: After this applicable if illed in by the funeral directors.

this

Box 68760.

Division of Vital Records, P.O.

Examiner

Physician/Medical

by

Completed

Be

Certification: To

edical

**Physician** 

/Medical

Examiner

Funeral

Director

flams 23s or 28s-f short

Demit. Pages 1 and 2 should be tiled within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-any injury or other traumatic event, the Medical Examples must be noted.

Baltimore, Maryland 21215-0020

Directo

Be

24e. Wes en eutopsy performed?

24b. Were autopsy tindings aveilable prior to completion of cause of death?

1 Yes 2 No

1 Yes 2 No

r: Nursing	5 Residence	6 Other
at	Describe how inj	

Specify) 28c. Injury a Work? 1 Yes 2 No

28t. Location (Street end Number or Rural Route Number, City or Town, State)

\*\*Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature end title of cept

5 Pending investigation

6 Could not be determined

29c. License number

Othe

29d. Date signed (Month, Day, Year)

30. Neme and address of p who completed cause of death (Item 23a) (Type, Print)

LIVINGSTON Rd FT WASHINGTON Md 20744 11701

State Registrar

12

JUN 0 2 2000

14

25. Wes case reterred to medical exeminer?

1 Yes 200

27. Menner of Deeth

2 Accident

3 Suicide

FRANK

31. Date filed (Mornin, Day, Year)

4 Homicide

32. Registrer's Signeture

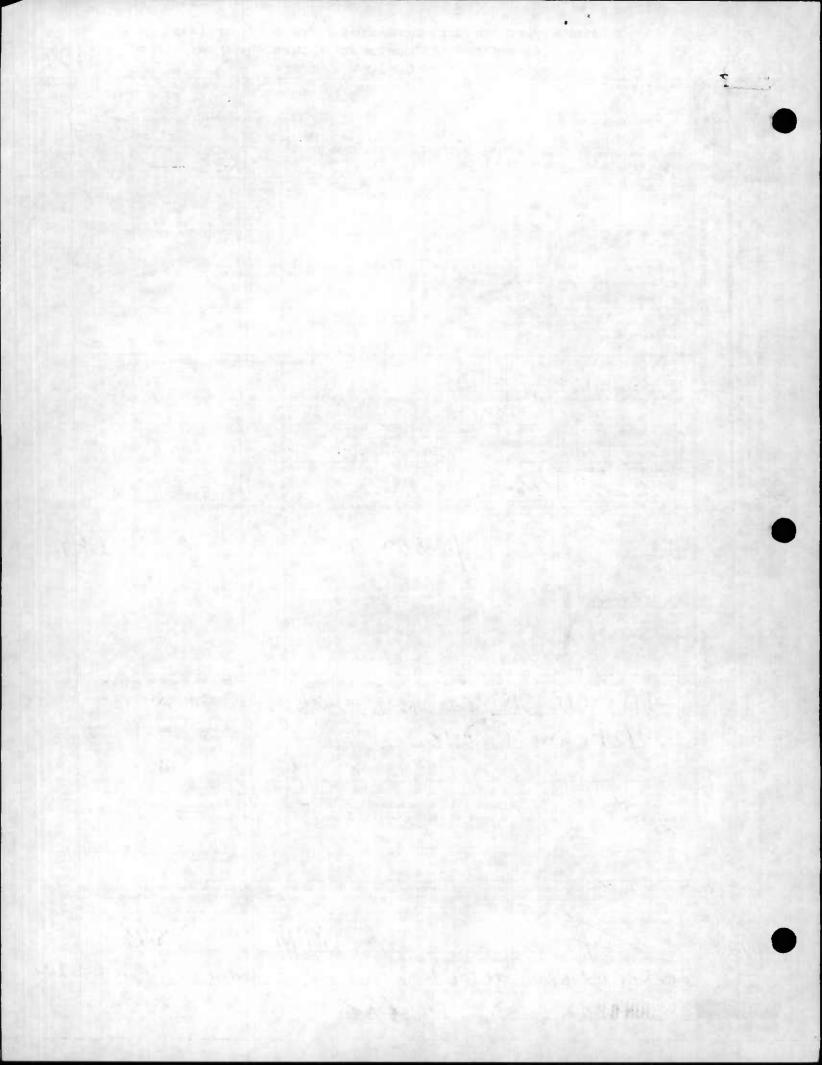
Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of tnjury

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

**DHMH 16 Rev 6/95** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 2000 May 11:25PM Clayton Funderburk, Jr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's 8. Date of Birth (Month, Day, Year) Oct. 27, 1954 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1₩ 2□ F Wash., D.C. 45 Yrs. 579-72-3442 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Show "natural", or items 23s or 28s-f show 1√2 Yes 2 No Director Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1205 Abel Avenue 20743 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Merried specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Š 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Falher's Name (First, Middle, Last) 1 end 2 should be fill lealth end Mental H im 27 is marked oth Be Clayton Funderburk, Sr. Roberta Lampkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 s Department of Health en Important: If them 27 is 1 any Injury or other traus once. 23464 Gay Funderburk - Sister 1137 Craftsman Dr., #101; Virginia Beach, VA 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 DBurial 2 □ Cremation 3 □ Removel from State Ft. Lincoln Cemetery 5/31/2000 Brentwood, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Aspiration Pneumonia Examiner Due to (or es a consequence of): Physician/Medical Examiner Acquired Immuno Deficiency Syndrome physician and s the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Central Nervous System Toxoplasmosis Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? pege 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate I or Attending Physician: after death.
Director: After this certifica director, Be 25. Was casa referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) complately filled in by 4 Homicide 24 hours a Hospital 29a. Certifier 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the ş 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) rle 800 d address of person who completed cause of death (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

Registrar

31. Date filed (Month, Day, Year)

3 1 2000

Box 68760

P.O.

Records,

Division of Vital

39. Registrer's Signature

# Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2 Data of Death 3. Time of Death **Physician** Frances M. Falcone May 24, 2000 4:50 p.m. /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Mo
If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Montgomery 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 DXF Yrs. Director 513-28-9478 Sept., 18,1934 Kansas Usuel Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ¥Yas 2 No Funeral Director Prince George's Hyattsville, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or Herna 23a 5605 36th Place 20782 S.A. 14. Race - Amarican Indian, 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status filed within 72 hours after 1 Yas 2 No
If Yes, Give
Yeer or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry al Hygiena. Elamentary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middla, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other traumatic event bates. 18. Mother's Nama (First, Middle, Maiden Sumama) Charles Francis Murray Loretta Genevieve Howe 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Vincent Falcone-Spouse 5605 36th Place, Hyattsville, MD 20782 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 Donation 2 □ Cremetion 3 □ Removal from Stata 4 □ Donation 5 □ Othar (Specify) Gate of Heaven Cemetery 5/27/00 Silver Spring, MD 21. Signatura of Funaral Sarvice, Dicenses 22. Nama and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD ases 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart teilure. List only one cause on each line. Approximata Intervel Between Onsat and Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in deeth) CArdiophurary Examiner Physician/Medical Examiner The lew requires that the death cartificate be executed burial-tran Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last P.O. Box 68760, Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? After this cartificate hes 2 1 No 1 ☐ Yas 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this carlification of the funeral director; the funeral director directors di Be 25. Was casa retarred to medical axaminar? 26. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Yas 2 No 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 27. Mennar of Death 28d. Describe how injury occurred 28b. Time of 5 Panding invastigation 1 Natural 1 Yes 2 No 2 Accidant 6 Could not be determined 3 Suicide 28e. Place of Injury - At homa, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, dete end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and mannar stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certitier 29c. License number 9707 medical Cortor pr. ecceille, md. 20120 MAllusale 30. Nama and addrass ot person who completed causa ot death (Itam 23a) (Type, Print) John M. Wallmark M.D. 31. Deta tiled (Month, Day, Year) 32 Registrar's Signatura State MAY 3 0 2000 Registrar

MAY 2 0 2000 0 2 4AM

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Clifton Howard Gray 2000 10:00 a.m. Tune /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Larkin Chase Nursing Home Bowie | Months | Days | Hours | Min. | November 16,1931 | WashingtonDC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 120 M 2□ F Yes. 68 Director 577 38 6553 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23s or 20706 9869 Good Luck Road #5 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status parmit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or he any injury or other traumatic event, the Medical Examins 1 El Yes 2 No
Il Yes, Give
Year or Dates: Unknown 1 Never Married 281 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black á 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Giant Food 12th Porter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) å Cora Vaughn Unknown Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9869 Good Luck Road #5 Lanham, MD 20706 Elizabeth Hart Gray/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland Harmony Memorial Park 22. Name and Address of Facility Marshall's Funeral Home of MD ure of Funeral Service Lic Buscol 4308 Suitland Road Suitland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) /Medical monthe Examiner Examiner certificate be executed ettending physician and for use es the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Athero Schenosis Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 100 08 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? id be detect 1 Yes 2 No 3 Probably 4 Unknown Mellitus þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; p. 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 45 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 1 Diatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kush anong 20108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K AKESH 14300 GALLANT FOX LANE 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State JUN 0 2 2000 Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death Month 3. Time of Death **Physician** Alfred Goodwin ٦r May 29, 10:15PM 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sax 6. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 125M 2□ F 58 Yrs. 579-52-7830 Director Dec 24,1941 South Carolina Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Landover 1X Yes 2 No Director or 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1707 Village Green Drive 20785 U.S.A. 238 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 XNo If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. filed within 72 hours after 1 Nevar Married 21 Merried Baltimore, Maryland 21215-0020 ò 1 Yes 2 XNo Specify: Black. Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Giva kind of work done during most of working life. DO NOT use retired) (Specify only highast grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Maintenance Worker 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Nema (First, Middla, Last) Be permit. Pages 1 and 2 should be t Department of Health and Mental Important: If Nem 27 is marked of any Injury or other treumatic eve Alfred Goodwin Sr Clair Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Elaine Goodwin 1707 Village Green Drive Landover MD 20785 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata tX Burlal 2 ☐ Cramation 3 ☐ Removel from State 6-3-00 Resurrection Clinton MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Service Licensee 22. Nama and Addrass of Facility J.B. Jenkins Funeral Home 7474 Landover Rd Landover MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Anterwesderone Cardiovacular Discarte Immediate Ceuse (Final disaasa or condition rasulting in deeth) /Medical Examiner Dua to (or as a consequence of): Physician/Medical Examiner ding physician and use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expects.) Dua to (or as a consequence of): Records, P.O. Box 68760. that initiated evants rasulting in death) Last Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 dnknown Respiratory failure Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Renal Failure 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatiant Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Daath 28e. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Neturel 5 Pending invastigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completaly filled in by the fun 1 Yes 2 No 2 Accidant 6 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To tha best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and mennar as stated 29a. Certifian 2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) MAY 30,2000 101852 30 Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)
PNI A. DEVUEF MD 47 12 (7) 4203 Queensbury Rd Hy attrille MD 20781 A. DEVUEF, MD 31. Data filed (Month, Day, Year) 32. Begistrar's Signatura State Registrar

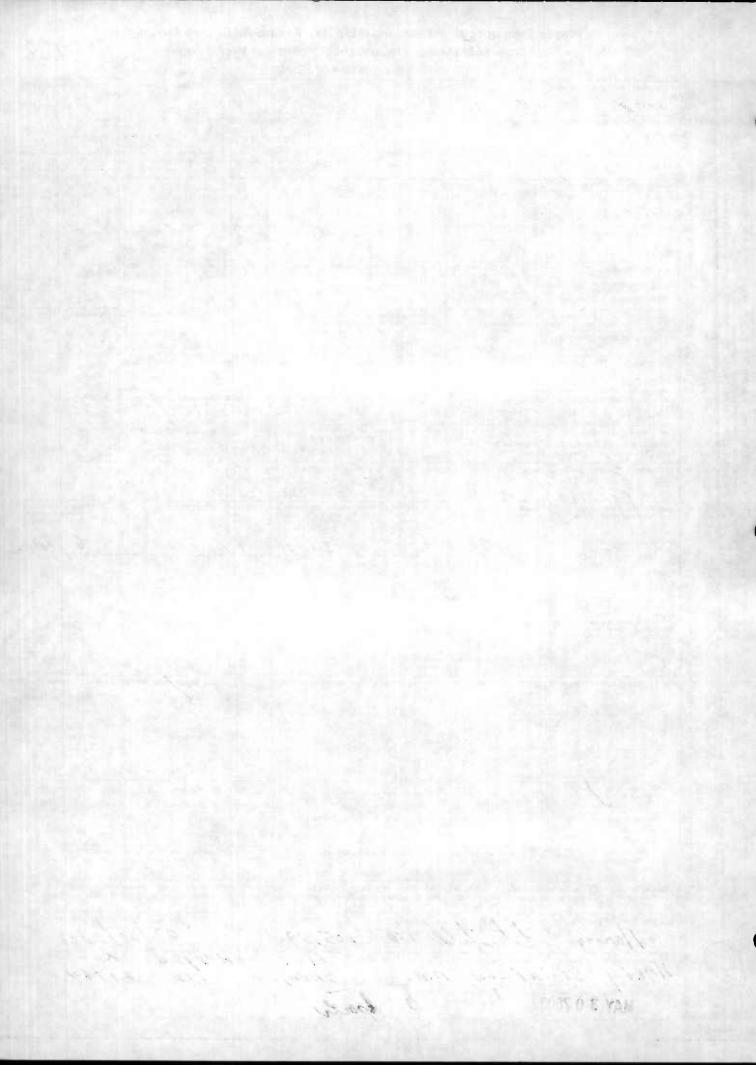
#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 2. Dete of Death 1. Decedent'a Neme (First, Middle, Last) 3. Time of Death May 29, 2000 **Physician** George Gordon Jr. 4:20 AM /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5031 Suitland Rd. Prince Georges Suitland If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth Month, Day, Year) July 20, 1945 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Washington, D.C. DOM 20 F 54 213-44-6735 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Maryland Mayo Director Anne Arundel must be notifi-10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code hams 23a or 4079 Cadle Creek Road USA 21106 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. filed within 72 hours after 1 Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 à 1 Yes 2XXNo Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry il Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Boat Builder Self-employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) of bend Mental F. Pages 1 and 2 should be George Gordon, Sr. June E. Campbell 19a. Informent'a Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health as Important: If Item 27 is any Injury or other tras. 5031 Suitland Rd. Suitland, Md. 20746 June E. Gladden/Mother 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dete 20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3 ☐ Removel from State Metropolitan Crematory 5/30/2000 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility George P. Kalas Funeral Home, P.A. 21. Signeture Funerel Service Licensee 6160 Oxon Hill Rd., Oxon Hill, MD 20745 alis 23a. Party Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) TETASTATIC PARS LING Examin r Due to (or es e consequence of) Examiner attending physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Laat Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es a consequence of) 23b. Did tobecco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Be Completed After this certificate has the funeral director, page 2 r 1 ☐ Yes 2 1 No 1 ☐ Yas 2 ☐ No is afterding Physician: The safer death.

In Director: After this certificated in by the funeral director, pi 25. Wes case referred to medical 26. Place of Death (Check only one) Mother's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ROther (Specify) 1 Yes 2 No Residence Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturet 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Ptece of Injury - At home, farm, atreet, fectory, office building, etc. (Specify) yd ni bellif 4 | Homicide To the Hospital of within 24 hours at To the Funeral Discompletely filled in \*\*EXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner es atlated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 05/30/2000 Ma Name and address of perion who completed cause of death (Item 23a) (Type, Print) SHADYSIDE KO STEINFELD 17.0. SHADYSIDE. MAY 3 0 2000 2. Registrar's Signature 31. Date filed (Month Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middla, Last) 2. Dete of Death **Physician** Harold 1 Howara 5:59 PM 05 2000 /Medical 4a Facility Neme (II not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 12M 2DF Months Days Hours 086-09-0649 Yrs. Director 11/24/1911 Macon, Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Prince George Directo Cheverly 20s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 1706 62nd Avenue 238 20785 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) natural, or flems 11. Merital Status 14. Race - American Indian. Black, Whita, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yas, Giva Yeer or Detes: à 3 ☐ Widowed 4 ☐ Divorced African American Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 1 2 College (1-4or 5+) Mail Clerk Government permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If them 27 is marked any injury or other to 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) ã John Howard Jessie Anderson 19a. Informant's Neme/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Carole F. Howard (Wife) 1706 62nd Ave. (Cheverly, Md. 20785) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Nother (Specify)Entombment 6/5/00 Brentwood, Md. Ft. Lincoln 22. Narpa and Addrass of Facility
Stewart Funeral Home, Inc. 21. Signature of Fr 4001 Benning Rd., N.E. (Wash., D.C. 20019) 23a. Pert1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear feilure. List only one cause on sech line. Approximete Interval Between Onset and Death Physician Immediate Ceuse (Final diseasa or condition resulting in daeth) /Medical Examiner Examiner Cardiomyopathy Sequentially list conditions, if any, teeding to immediate causa. Enter Underlying Cause (Diseese or injury that initieted events rasulting in death) Lest Due to for as a conse burial-tran attending physician Records, P.O. Box 68760 In sufficience 8 Physician/Medical Dua to (or as a consequence of): ementa Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Wes casa rafarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No edical Certification: To 1 Inpatient 28c. Injury et Work? 27. Mennar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending invastigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28a. Ptace of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Cartifiar Certifying Physician: To tha best of my knowledge, death occurred et the tima, data end place, and dua to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Takoma Park, MD 20912 7600 Carroll Ave.

**DHMH 16 Rev 6/95** 

State

Registrar

lartin Brown, MD

31. Dete filed (Month, Dey, Year)

JUN 0 2 2000

32. Registrer's Signetura

Harrie L. Hourn

0.5 30 2000 5:54 M

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Hartin Brown Mis Live Liver A Proc Tohan List Mr 2344-

Please	Type or Print in E State of Marylan	d / Department o	of Health and I		_	e. 19204
Decedent's Name (First, Middle, Las	-41	Certificate	or Death		g. No.	o Thursd David
				2. Date of Death	Day Y	3. Tima of Death
	Harkleroad				6, 2000	11:10 pm
4a. Facility Name (If not institution, give			4b. City, Town, or		4c. County of	
Sacred Heart Ho		est birthday) If Under 1 Y	Hyatts\ eer   If Under 24 Hrs.			George's
5. Social Security Number 6. S. 579-22-6645  Usual Residence of Decedent	ex 7. Age (In yrs. I	Months D	ays Hours Min.		Year) , 1907	Birthplace (Stete or Foreig Country) Virginia
10a. State 10b. County  Maryland Prince (	_	Mt. Rainier				10d. Inside City Limits
10e. Street and Number		10f. Zip Co	de	10	og. Citizen of Wha	at Country?
3704 Shepherd Str	reet	2	20712		U.S.A.	
11. Marital Status	12. Was Decadent Ever in U,		of Hispanic Origin? (S	pecity Yas or No-	14. Raca -	Amarican Indian,
1 ☐ Nevar Married 2 ☐ Married 3 █ Widowed 4 ☐ Divorcad	Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates:	1 ☐ Yes 2 <b>X</b> ☐	Cuban, Maxican, Puert No Specify:	o Hican, etc.)	Specify:	White, atc. White
15. Decadent's Ed (Specify only highest gre	lucation de completed)	16a. Decedent's Usual O	one during most of wor	rking	6b. Kind of Busin	ness/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker	etired)		Our Ho	mo.
17. Father's Name (First, Middle, Last)		Homemaker		me (First, Middle, N	Own Ho	ine
	liher					lable)
19a. Informant's Name/Relationship (7		19b. Malling Address (Si		Katherine		
1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Bignature of Funerit S vice Local 23a. Part Enlas the disease of comparison or heart failure. Let only of the sease of condition resulting in death)  Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or Due to (or d. D. Due to (or d. D. Due to (or d. D. Due to (or d. D. Due to (or d. D. Due to (or d. D. Due to (or d. D. Due to (or d. D. Due to (or d. D. Due to (or d. D. D. Due to (or d. D. D. D. D. D. D. D. D. D. D. D. D. D.	Gasch's 4739 Ba1 on not enter the mode of the secons and the secons as a consequence of):  As a consequence of):  As a consequence of):  As a consequence of):	ddress of Facility Funeral Hotimore Ave dying, such as cardiac	ome, P.A. enue, Hya c or respiratory arre	ttsville	Approximate Interval Batween Onset and Death  3
Hxpertension	Congestive	elleart F	uilure,	1 🗆 Ye	8 2 No 3	☐ Probably 4 ☐ Unkno
Sick Sinus S	Synd-ome m	eith Pacen	naker.	24a. Was ar perform		24b. Ware autopsy findings available prior to completion of cause of death?
				1 □ Ye	s 2 No	1 ☐ Yes 2 ☐ No
25. Was case raferred to medical examiner?	1 de critedo			ath (Check only one	9)	
1 Yes 2 No	1	ER/Outpetient 3□ DOA	Othar: 4 Nursing H	fome 5 ☐ Reside	nce 6 Other	(Specify)
7. Manner of Daath  1 Natural 5 Pending  2 Accidant investigation  3 Suicide 6 Could not be		28b. Time of Injury M	fnjury et Work? 1  Yes 2 No	28d. Describe ho		
4 Homicida detarminad	building, etc. (Specify			City or Town	, Stete)	or Rural Route Number,
29a. Certifier 1	/sician: To the best of my know iner: On the basis of examinate and manner stated.	viedge, death occurrad at the ion and/or investigation, in i	na tima, data and place my opinion, daath occu	i, and dua to tha ca irred at the tima, da	usa(s) and mann ita and placa, and	er as stated. I dua to tha causa(s)
29b. Signature ag Stie Scarffer	P.A	29c. Li	cense number		od. Date signed (/	Month, Dey, Year)
30. Nama and address of person who of	complated tausa of death (Item	23a) (Type, Print) <b>7</b> 5	) 31001 so Greenbelk,	MA. 2	ntr. Dr.	#430

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attanding Physician: The law requires thet the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the bunel-transit

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

mit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, in Medical Examinet must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

0 1 2000

Seneral

1. Sports

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State of Maryland / Department of Health and Mental Hygiene 00 19205

						Ceru	ilicate of	Dealli		Reg. No.		
	Physician /Medical	DAVII		. HAI	GLER, S	R.			2. Date of D Month May 29	9, <sup>Day</sup> 2000	Year	3. Time of Death 1:30 pm
	Examiner		o (If not institution, givington Adve		pital			4b. City, Town, o	or Location of Dea Park	th 4c. County Montg		у
	Funeral Director	5. Social Security  577-66- Usual Residence	Number 6. S -2957		e (In yrs. last bin		If Under 1 Year Months Days		a. Dete of B. (Month, D. Feb. 2	irth Pay, Year) 5, 1951	9. Birthr Cour Wash:	olace (Stete or Foreign (17)) Lington D.C.
	Para Manual	10a. State	10b. County		10c. City, Town	n or Loca	ation	731			1	Od. Inside City Limits
	Mary	D.C.	N/A		Washi	ingto	on				4	1 A Yes 2 No
	vith the Mail or 28a-fa be notified Director	10e. Street and N	lumber				10f. Zip Code	6.0,1		10g. Citizen of V	Vhat Cour	ntry?
	with with ID	7010 00	orgia Aver	N H				20012		U.S	.A.	
120	fied within 72 hours after death with the Maryland thygiene. ther than "natural", or items 23s or 23s-f show out, the Maryland Evantine must be notified at a Completed by Funeral Director	11. Merital Stetus		12. Was Decedent Armed Forces?  1  Yes 2  hr			as Decedent of /es, specify Cul	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	Bled	e - Americ k, White, Bla	
21215-0020	thurs the	0.577100400	15. Decedent's Ed		16a	Deceder	nt's Usuel Occu	nation		16b. Kind of Bu	siness/in	dustry
15	ed within 72 ho yglene. er than "natura ft, or H. Arall Completed		ecity only highest gra	ide completed)		(Give kil	nd of work done NOT use retin	during most of w	vorking	10011111100100		
212	should be filed within and Mental Hyglene. marked other than imetic event, the Mental To Be Comp	Elementary/Se 12th	condary (0-12)	College (1-4or 5	Che					Walter	Reed	Hospital
	be filed d other event, Be C		e (First, Middle, Last)	)	CII			18. Mother's N	lame (First, Middle	e, Maiden Sumem		
an	Mental H Mental H arked out rtic ever	John C	. Haigler					Pearl F	oxworth			
Maryland	2 should and Men sements marked		Name/Relationship (	Type, Print)	19b	. Meiling	Address (Stree	at end Number or	Rurel Route Num	ber, City or Town,	Stete. Zic	Code)
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9	s 1 and 2 sh I Health and tem 27 is m other traum	20a. Method of D		8	20b. Piace of	Disposit	tion (Neme of		Date	20c. Location -	City or To	own, State
ō	00-		2 ☐ Cremation 3 ☐		10-11-		con or other pla		6-2-00	Washingt		
Baltimore,	permit. Pages 1 a Department of He Important: If Item any Injury or othe price.		5 Other (Specif		Grenwe		Cemeter		1		on D	0
Bal	mpo mpo my li	21, Signeture of	Funeral Service Licer	1500	00				al Home,			
		th	ha T	Mash	all	4	217 9th	Street	N.W. Was	shington	DC 2	0011
		23a. Parti Ente shook, or he	r the disease, or comeent feilure. List only	plications that caused one cause on each in	the death. Do no.	not enter	the mode of dy	ring, such as card	iac or respiratory	arrest,		Approximate Interval Between
	Physician											Onset and Death
M	/Medical	Immediate Cause diseese or condit	tion	· RGS	PIKAT	OR	-4 1	LAIL	IRE			2 648
	Examiner	resulting in deeth	1)	0.	Due to (or as a	conseque	ence of):	W	G CAT			
ь				ME.	TA & TA	T	16	LUN	G CAT	VER		- MUNTH
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68760,	n certificate be anding physicia use as the bu	that initiated ever resulting in death	or injury nts	C	Due to (or es e o	conseque	ence of):					
89	Aed Aed	resulting in death	i) Last									
XO	endii ruse			d								
8	d by the attered for the Physicial	Pert II. Other sign	nificant conditions c	ontributing to death bu	ut not resulting in	the und	lerlying cause g	iven in Part I.	23b. Dic	tobacco use co	ntributa t	o the causa of death?
P.O.	uires that the dei is signed by the a iid be detached f d by Physic		A STATE OF THE RESERVE OF THE PARTY OF THE P	VONA					N	hYes 2□ No	3 □ Pro	bably 4 Unknown
	es that igned be de	307	CHOIC IC	VENT	OFI	V F1	7 7 70 8	11-0110	_ /			
Division of Vital Records,	n sig									s an autopsy	24b. W	ere eutopsy findings
00	w require been si should							0.0	pen	formed?	CC	rallable prior to empletion of cause death?
Re	The law requir								45	Yes 2000		
a	certificate has rector, page 2	OF Monones and	arrad to madical									Yes 2 No
5	Physician: r this certific and director, TO Be (	25. Was case ref examiner?		Hospital:		VEW 2000	0	ther:	Death (Check only			
o	Physic this c rai dire	1 Yes 2	No	28e. Date of Injur		tpatient Time of	3LI DOA	4 LI Nursing		sidence 6 Oth how injury occur		(y)
LC.	After fune	1 Natural	5 Pending	(Month, De)	Year) I	njury	28c. Inju	ork? ]Yes 2∐No	200. 2000.	, non injury occur.		
S	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	2 Accident 3 ☐ Suicide	6 Could not be		ini. At home fo	rm ctroo			28f. Location	(Street end Numb	er or Run	el Route Number
2	attar deatl Director: d in by the	4 Homicide	e determined	28e. Place of Injubuilding, etc	(Specify)	rm, stree	n, lactory, office	,	City or To	own, Stete)	or or riur	ar riodie riomber,
Ц	Hospital or 24 hours after Funeral Directly filled in Mary filled in	00-01-99	<del>-</del> /									
	he Hospi in 24 hou he Funer pletaly fill edical	29a, Certifier (Check only	2 Medical Exam	yalclan: To the best of niner: On the besis of	examinetion and	dor inve	stigation, in my	opinion, death of	ce, and due to the courred at the time	e cause(s) and me , dete end plece,	nner as s and due t	o the cause(s)
	To the Hospital or within 24 hours after the Funeral Dir completaly filled in Medical Cert	one)	Of title of co-Or	and manner sta	te0.		200 1 ince	nse number		29d. Date signe	d (Month	Opu Veer)
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	(10)	Name and ad	A. G.	Completed Sause of di	eath (Item 23a) (	Type, Pr	CRCA	NTRE	LANG.	LARGO	, MD	, 20774
	State Registrar	31. Date filed /Mc	un 0 1 200	32 Registrs		4.	books					
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 19206 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Physician May 26, Maria 2000 Hajdur 2:35 PM /Medical 4e. Fecllity Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 10642 Tippett Road Clinton Prince George's If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Pay, Year) March 4, 1909 Belarus 9. Birthpiece (State or Foreign **Funeral** Deys Months Hours Min 577 48 0691 91 **Director** Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any jointry or other traumatic event, the Meuical Examiner must be noticed and page. 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD P.G. Clinton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 10642 Tippett Road 20735 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a Packer Mann's Potato Chip Co. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philip Katushonak Daria Saschok 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valentina Makowelski/Daughter 10646 Tippett Road, Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) May 30, 2000 20c. Location - City or Town, Stete XX Burial 2 Cremetion 3 Removel from Stete Rock Creek Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Washington DC 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Servica Licanses Alexandria Ferry Road, Clinton, Maryland 20735 23e. Pert1. Enter the disease, or complications that caused the shock, or heart feilure. List only one cause on each line Do not enter the mode of dying, such es cardlac or respiretory arrest, Interval Between Onset end Deeth Physician /Medical immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed use as the bunal-transi Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest P.O. Box 68760. Physician/Medical Due to (or es e consequença of) Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 3 No 3 Probably 4 Unknown been signed by Division of Vital Records, Q Completed 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? certificata has 2 1/No 1 Tyes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 25 N Other: 4 ☐ Nursing Home Residence 8 ☐ Other (Specify) 2 1 Yes Aftar this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Naturel 5 Pending investigation death. 1 Yes 2 No 2 Accident in by the f Director: 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled 29a. Certifier McCartifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, and due to the ceuse(s) and manner es steted.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) and manner es steted. 29b. Signeture and liftle of cartifier 29d, Date signed (Month, Day, Year) 29c. License number

State Registrar

31. Dete filed (Month, Day, Year)

MAY 3 1 2000

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)

Rene Earle Grace, M.D. 9131 Piscataway Rd, Clinton, Maryland 20735 3. Registrar's Signeture

nay 3 con

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State of Maryland / Department of Health and Mental Hygiene

19207

				C	ertificate of	Death	Re	g. No.	0 195	UI
Physici /Medi		Decedant's Nama (First, Middla, NORMA	RUTH HACKMA	N			2. Data of Daath	, Day 200	3. Time of 4:05	-
Examir		4a. Facility Nema (If not institution, g	iva straat and number) UTHERAN HOME			4b. City, Town, or L		4c. County of MON	of Daath	
, Funeral Director		260-20-1321	Sax 1□ M 2XF 7. Aga (In yrs. 88		y) If Undar 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, DEC • 23	Yaer) , 1911	9. Birthpleca (Stata o Country) MISSISSI	r Foraign
Maryland I-f show	tor	Usual Rasidance of Dacedant  10a. Stata 10b. County MON	TGOMERY 10c. Ci	ity, Town or	Location ROCKV	ILLE			10d. Insida Cii 1 X Yas	-
ter death with the Marylan Items 23a or 28e-f show Det must be notified at	al Director	10e. Street and Number 9531 VEIRS	DRIVE #1		10f. Zip Code	0850	10	g. Citizan of W		
6 9 E	by Funeral	11. Marital Status  1 Navar Merried 2 Married 3 Noved 4 Divorced	12. Was Decedant Evar In L Armad Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas:	J,S. 13	8. Was Decedant of I If Yas, specify Cub		acify Yas or No- Rican, atc.)		- American Indian, , White, atc. WHITE	
within ene. than	Completed	15. Decedent's (Spacify only highast g Elamantary/Secondary (0-12)	Education rada complated)  Collaga (1-4o; 5+)  4 YRS	16a. Dec (Giv lifa	eedent's Usual Occup ya kind of work dona DO NOT use retire HOMEMAK	during most of work d)	ing	6b. Kind of Bus	HOME	
should be filed and Mental Hygis marked other umatic event, II	To Be C	17. Father's Nama (First, Middla, La.  JOHN W. MA	•				a (First, Middla, MidUCKELR)		)	
12 sho h and lis me traum		19a. Informent's Name/Relationship MR • ALAN HACKM		19b. Ma 8538	lling Addrass (Streat B - HAYSH	end Number or Run	el Routa Number, COLUMBI	City or Town, SA, MD • 2	Steta, Zip Code) 1045	
Peges 1 end nent of Healt int: If Item 2 ury or other		20a. Mathod of Disposition  1 XBurial 2 Cramation 3 4 Donation 5 Other (Spec	□Removal from State ST •	Placa of Disposantary, cr ANDR I	position (Nama of rematory or other pla EW LUTH •	CEMETERY	Data 20	Oc. Location - C	City or Town, Stata A, SOUTH	CAI
permit. Pege: Department of Important: If I any Injury or once.		21. Signature of Funaral Service Lic	2-0		22. Nama and Addra HYSON	G CO., IN	NC.			
certificate be executed ding physician end se as the bunal-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immadiate causa. Entar Undarlying Cause (Diseesa or Injury that initiated evants rasulting in death) Last	b. Atri Due to (c	or as a conse	i hear	ation of Fac			les 3 n 10 ye	an
	Physician/	Parl II. Other significant conditions Chrome Ane				van in Part I.			ribute to the cause o	
as been signe 2 should be d	Completed by	CM Own And	new, 1+ price	4	3		24a. Was an performe		24b. Wara autopsy fi avallabla prior fo completion of ce of death?	)
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h. After th funeral	2	axaminar?  1 Yas 2 No  27. Menner of Death 1 Natural 5 Panding 2 Accident Invastigati	28a. Date of Injury (Month, Dey Year)	ER/Outpatk 28b. Tima Injury	of 28c. Injur	nar: 4 Nursing Ho	me 5 Rasidan 28d. Dascribe how	ca 6 □Other		
s effer death. I Director: After death. In Director: After death. In Director: After death.	Certification:	3 Suicida 6 Could not datamine	28a. Place of Injury - At h building, atc. (Specif	oma, farm, s	streat, factory, office		28f. Location (Stra City or Town,		r or Rural Route Numb	oar,
in 24 hour	edical	29a. Cartifiar (Check only 2 Medical Exa	hysician: To the best of my kno minar: On the basis of exemine and mannar steted.	wledga, dea tion and/or I	th occurred at tha tir nvestigetion, in my o	na, date and place, pinion, deeth occurr	and dua to tha cau ed at tha tima, date	sa(s) and man e and placa, an	ner es steted. nd due to tha cause(s)	
Tot	2	29b. Signature and title of Certifies	mm m	1.1	7, 29c. Licens	a number 366/8			(Month, Day, Year) 26, 2000	)
20)		30. Nama and address of person who DR • C • S	completed cause of death (Item CHEMM- 9701-			., ROCK		/		
Star Registra		31. Data filed (Month, Day, Year) MAY 3 0 2000	3. Regisfrar's Signa	atura .	Locale					

DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Da Month **Physician** May 28, Olivia Luminda Hurd 2000 6:05 pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Genesis Eldercare La Plata Charles If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Montha Hours 1 □ M 2 🗓 F 88 Yrs 577-07-9457 July 15, 1911 Director California Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shores Medical Examiner must be notified at 1 X Yes 2 No Director Maryland Prince George's Lanham 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 8002 Tiffany Lane 20706 U.S.A. Funeral 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Datas: 1 Never Merried 2 Married 21215-0020 1 Yes 2 No Specify. Specify: Completed by 3 N Widowed 4 Divorced White 16a. Decedent'a Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 8 Laundry Supervisor Medical Facility Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If flem 27 Is marked other any Injury or other traumatic event, parket. 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Surneme) Be Delis Collier Alford Charlotte Pickney 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 38245 Walter Court, Charlotte Hall, MD Judith M. Roediger - Niece 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stata 20a. Method of Disposition Dete 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removel from State 6/01/2000 Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funaral Sarvice Licemen Gasch's Funeral Home, P.A. 4739 Baltimore Avneue, Hyattsville, MD 20781 MAM 23a. Partt. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physicián /Medical Immediate Ceuse (Finel Metastatic Carcinoma of Breast disaese or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner Interstitial Lung Disease The law requires that the death certificate be axecuted bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarfying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): pue Box 68760, physician Physician/Medical the Dua to (or as a consequence of) for use as 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. be detached 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? should complation of cause of death? **pege 2** certificate has 1 Yes 2 No 1 Yas 2 No Physician: funeral director. 25. Was case referred to medical exeminer? edicai Certification: To Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4X Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No this 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Division or Attending 5 Pending investigation 1 X Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 1 Yas 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(a) end manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the causa(s) and menner stated. 29a. Certifiar (Check only one) 29c. Licensa number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 145737 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar Gurusamy, M.D.,

31. Date filed (Month, Dey, Year) MAY 3 0 2000

72. Registrar'a Signeture

6 Post Office Road, #103, Waldorf, Maryland

20603

# Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Ida Mary Hales May 2000 23 14:29PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 16, 1913 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2□xF 577-26-4585 86 Yrs. Virginia Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Maryland Prince George's r 28a-f Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 늄 8 700 Castlewood Drive 20774 Nems 23a United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) t4. Race - American Indian, 11 Marital Status Black, White, etc. African 1 Never Married 2 Merried natural, or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 Ď Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementary/Secondary (0-12) 12th Coilege (1-4or 5+) Bindery Machine Operator Government permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If Item 27 is merited other any injury or other treumetic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Hunter Mundy Mary Kelley 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald C. Hales - Son 2907 Sherman Ave., N.W. Wash., D.C. 20001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State Washington National Cem. 5/31/2000 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. REETO 20019 23a. Part 1. Enter the disease, or complications that cause if the disease, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical ARTERIOSCIENOTIC CANDIOVASCULAR DISEASE Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai that initiated events resulting in death) Last Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Artemal Hypertension Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Dementia 1 ☐ Yes 2 K No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 8 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA 1 Yes 2 No edical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturat 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 001852 MAY 24 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEVORE MD 4203 Queensbury Rd Hyattsville MD 20181 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

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Registrar

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31. Dete filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

no

32 Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

34.8 \$ 0.2800 Comments

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death **Physician** May 24, Betty J. Hungerford 10:10 PM 2000 /Medical 4e Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges H Under 1 Yaar | If Under 24 Hrs. | 8. Deta of Birth | 9. Birthpleca (Stata or Foreign (Month, Day, Year) | 9. Country) | March 25, 1927 | West Virginia 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) **Funeral** Months 1□M 2NF 73 Yrs 234-40-7115 Director Usual Rasidence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 K No Directo Virginia Prince William Woodbridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 2213 Princess Anne Lane 22191 USA 238 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygieno. Important: if Nem 27 is marked other than "natural", or then any injury or other traumatic event, the Medical Examples. Black, White, etc. 1 Navar Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ 3℃Widowed 4 Divorced Yaar or Detas Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) Homemaker At Home 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be Alexander D. Rosenbaum Alma Grav 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William V. Hungerford, Jr./Son same as item 10 20b. Piace of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 6/1/2000 Cheltenham, MD 21. Signature of Furaral Sarvice Licensee 22. Nama and Addrass of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 als 23a. Pand fifter the disease, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiretory arrest, and or heart feiture. List only one cause on each line. Approximata Intervel Between Onset end Death **Physician** fmmediata Ceuse (Finel disaesa or condition resulting in death) /Medical ARTERIO SCLEMOTIC CANDIOVASCUAR YEARS Examiner Dua to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or trijury that initiated events rasulting in death) Lest Dua to (or as a consequence of): Box 68760. Dua to (or es a consequence of): P.O. 1 Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown Records, Be Completed by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural 5 Panding invastigation effer death. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 100 4 Homicida To the Hospital or within 24 hours eff To the Funeral Di completely filled in 29a. Cartifier 💢 Certifying Physician: To tha best of my knowledge, daath occurred et the tima, data and place, and dua to tha cause(s) and mannar as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and menner steted. 29b. Signatura end titia of certifiar 29c. License number 29d. Data signed (Month, Day, Year) and eddrass of person who complated causa of daath (Item 23a) (Type, Print) D-18545 LINE CENTER CHALDONF, Md. 20602 112011KH MY

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey Year Month **Physician** Marie Brown Jordan May 31, 2000 3:08 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 13636 Poplar Grove Road Hagerstown Washington If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2\ F Yrs. 217-14-7602 94 Director May 29, 1906 Pennsylvania Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow rai', or items 23a or 28a-f shov Examiner must be nothind at 1 ☐ Yes 2 N No Director Maryland Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 13636 Poplar Grove Road 21742 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Coahnit. Peges 1 and 2 should be filed within 72 hours after cooperation of Health and Mental Hygiene. Introduction: if them 27 is marked other than "natural, or item any Injury or other traumatic event, the Medical Experience on the company injury or other traumatic event, the Medical Experience on the company injury or other traumatic event, the Medical Experience on the company injury or other traumatic event, the Medical Experience of the company injury or other traumatic event, the Medical Experience of the company injury or other traumatic event, the Medical Experience of the company injury or other traumatic event, the Medical Experience of the company injury or other traumatic event, the company injury or other traumatic event, the company injury or other traumatic events. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 2 White 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Navv-Elementery/Secondery (0-12) College (1-4or 5+) 10 U.S. Government Supervisor of Accounts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry E. Brown Mary Jane Carroll 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Maureen M. Warner - Daughter 13636 Poplar Grove Road, Hagerstown, MD 21743 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Locetion - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 6/04/2000 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 el. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) my Alzleineri Dinen Examiner Due to (or as a consequence of): Examiner physician and s the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): P.0. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 3 Uniknown Anterio relentic cardiover ander signed to Dinen Records, à 24b. Were autopsy tindings avellable prior to completion of cause of death? Completed 24e. Was an autopsy auto varante tecider , nopothyrashin page 2 Anemia 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Atter 1 PNatural 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident after deeth Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) á 4 Homicide C filled hours a 24 hours 29a. Certifier 13-certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar

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**DHMH 16 Rev 6/95** 

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31. Date filed (Month, Day, Year)

32. Registrer's Signeture

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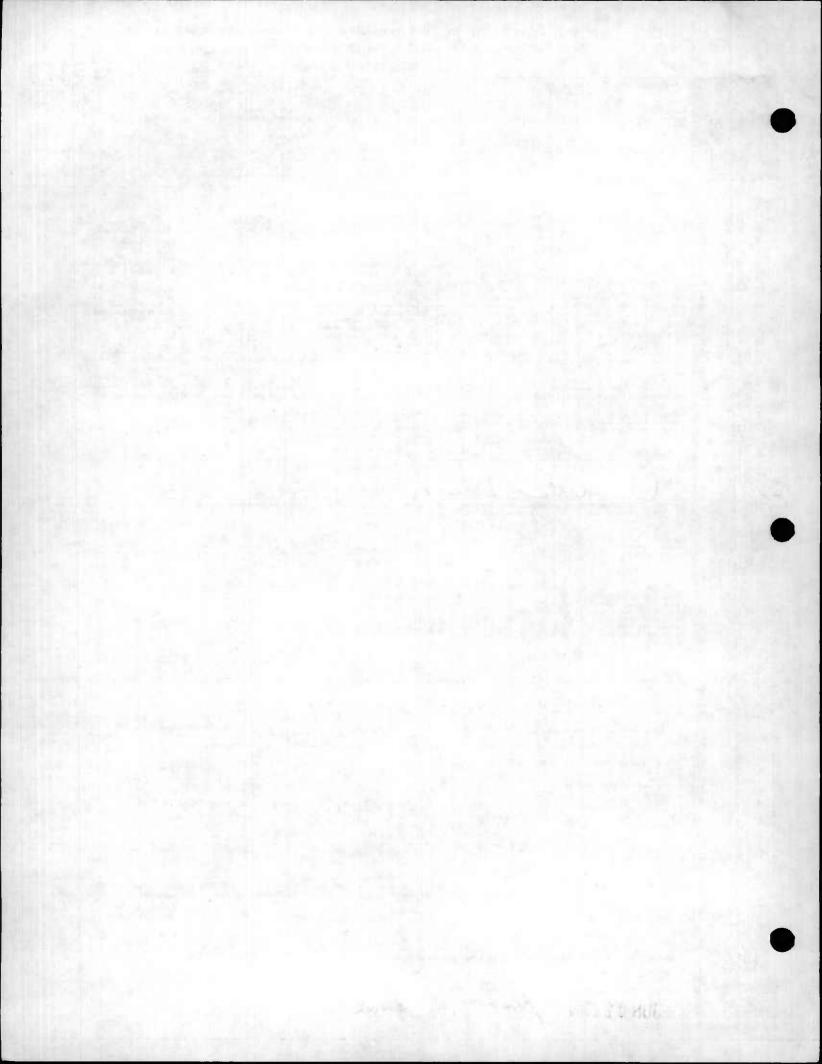
334 MILL ST HAGERSTOWN, MO 21740

IVNE 1, 2000

- (ZNE M)

DATTA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death Day Month Year 1045 AIM MSOI MAY 30 2000 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death CHEVERLY, PRINCE GEORGE PRINCE GEORBES HOSPITAL CENTER 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthpleca (Stata or Foraign Country) 5. Social Security Number 6. Sax Days M 20 F Yrs. 223-40-7302 66 May 9, 1934 Virginia Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 □Was 2 □ No Prince George's Maryland Forestville 10e. Street and Number 10f. Zio Coda 10g. CitIzan of What Country? 2130 Brooks Dr., #314 20743 United States 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ऒ No If Yas, Giva Yaer or Datas: Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No Spacify: Specify: Black 3 Widowad 4 Divorced 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elemantary/Secondary (0-12) Collega (1-4or 5+) 9th Construction Worker Private 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Charlie Johnson Rosie Dickerson 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Ruby L. Johnson - Wife 2130 Brooks Dr., #314; Forestville, MD 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete Cedar Hill Cemetery 6/5/2000 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Stewart Funeral Home 22. Name end Address of Facility gNFuneral Service Lic 4001 Benning Rd., N.E. Wash., D.C. 20019 Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Daath Immediata Causa (Final ENTRICULAR ARRYTHMIA disaasa or condition resulting in deeth) Dua to (or as a consequence of): CARDIAL DISEASE ATHEROSCLEROTIL Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated avants resulting in death) Last Dua to (or as a consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown CVA 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was en autopsy 2 No 1 ☐ Yas 2 ☐ No 1 Yas 25. Was case referred to madical 26. Placa of Daath (Check only ona) axaminar? Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 28c. Injury at Work? 27. Manner of Daeth 28e. Data of Injury (Month, Dey Year) 28b. Time of 28d. Dascribe how Injury occurred 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be detarmined 3 Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At homa, farm, streat, factory, office building, etc. (Spacify) 4 Homicide

Examiner The law requires that the death certificata be executed Box 68760 Records, Division of Vital

attending physician and for use as the bunal-transit been signed t should be deta is certificate has b Hospital or Attending Physicien: 24 hours after death.
Funeral Director: After this certifice stely filled in by the funeral director, p To the Hospital or within 24 hours aft.
To the Funeral Dir completely filled in

**Physician** 

/Medical

Examiner

Funeral

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Certification: To

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29a. Cartifiar (Check only one)

**Funeral** 

Director

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counit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan
consument of Health and Martal Hygiene.
Important: If item 27 is marked other than "natural", or itsma 23a or 28a-1 show
may injury or other traumatic event, the Medical Examiner must be notified a

**Physician** /Medical

Baltimore, Maryland 21215-0020

State Registrar 29b. Signeture and title of certifier Jusan W Owenship 29c. Licensa number D22751

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end mannar es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29d. Data signed (Month, Day, Year) MAY 30, 2000

30 Nama and address of person who completed cause of death (Itam 23a) (Type, Print)
PRINCE GENGE'S HOSPITAL CENTER

Susan W. Owens, MD Per 14, Mary land Cheverly

31. Data filad (Month, Day, Yaar) 32. Ragistrer's Signature JUN 0 2 2000

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State of Maryland / Department of Health and Mental Hygiene 00 19214

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	Maryland		al S	System			cation of Deeth	4c. County	of Death	11.2	5 pii
219-42-4341 Usual Residence of Decedent	Sex 7. Ag	ge (In yrs. lest b		If Under 1 Yee Months Dey		Min.	6. Date of Birth (Month, Day, July 20	Year) ,1944		lace (State of try) ingtor	
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10e. Street and Number 14618 Old Stage	⊋ Rd			101. Zip Coda 2071	6		10			try?	
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25. Was case referred to medical					OC Disease	of Dooth			10	Yes 2⊠	No
examiner?  1 Yes 2 No  27. Mennar of Death  1 Neturel 5 Pending	28e. Dete of Inju (Month, De	/ry 28b		28c. Inj	ther: 4□ Nu uny at ork?	rsing Hor	ne 5□ Reside	nce 6 🗆 Oti		y)	
3 Suicide 6 Could not b determined	286. Pieca of in	jury - At home, ic. (Specify)	ferm, strae	et, fectory, office	9	12	28f. Location (St City or Town	reet end Num n, Stete)	ber or Rure	I Route Num	ber,
	niner: On the basis of	f axamination a									\$)
29b. Signature end title of certifier	11 11+.			29c. Lice	nse number		25	9d. Dete signe	d (Month,		
30. Name and addrass of person who	completed cause of c	deeth (Item 23a	) (Type, Pr	rint)	2430	<u> </u>	1	Nay	31	200	0
	11. Maritel Stetus  1 Never Merried 2 Merried  3 Vidowed 4 Divorced  15. Decedent's Eigenentary/Secondery (0-12)  9  17. Fether's Neme (First, Middle, Last, Norman P. Johns Shirley Johns  19a. Informant's Name/Reletionship (Shirley Johns  20e. Mathod of Disposition  1 Surial 2 Cremation 3 Amended to Disposition  21. Signeture of Fureral Service Licer  22a. Pert1. Enter the disease, or come shock, or heart feilure. List only  Immediate Causa (Finel disease or conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Influry that initiated evants resulting in death) Last  Pert II. Other eignificant conditions of the cause (Finel disease) or condition resulting in death)  25. Wes case referred to medical examiner?  1 Yes 2 No  27. Mennar of Death  1 Neturel 5 Pending investigation and provestigation of the determined of the condition of the condition of the determined of the condition of the determined of the condition of the conditio	11. Maritel Stetus  1	11. Maritel Stetus  1 Never Merried 2 Merried 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  17. Fether's Neme (First, Middle, Last)  Norman P. Johnson  19a. Informant's Name/Reletionship (Type, Print)  Shirley Johnson—Wife  20e. Method of Disposition  18 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signeture of Furferal Service Licensee  23a. Pert1. Enter the disease, or complications that caused the death. Do shock, or heart feilure. List only one ceuse on each line.  Immediate Causa (Finel disease) or complications that caused the death. Do shock, or heart feilure. List only one ceuse on each line.  Immediate Causa (Finel disease) or complications that caused the death. Do shock, or heart feilure. List only one ceuse on each line.  Immediate Causa (Finel disease or conditions, if any, leading to immediate cause. 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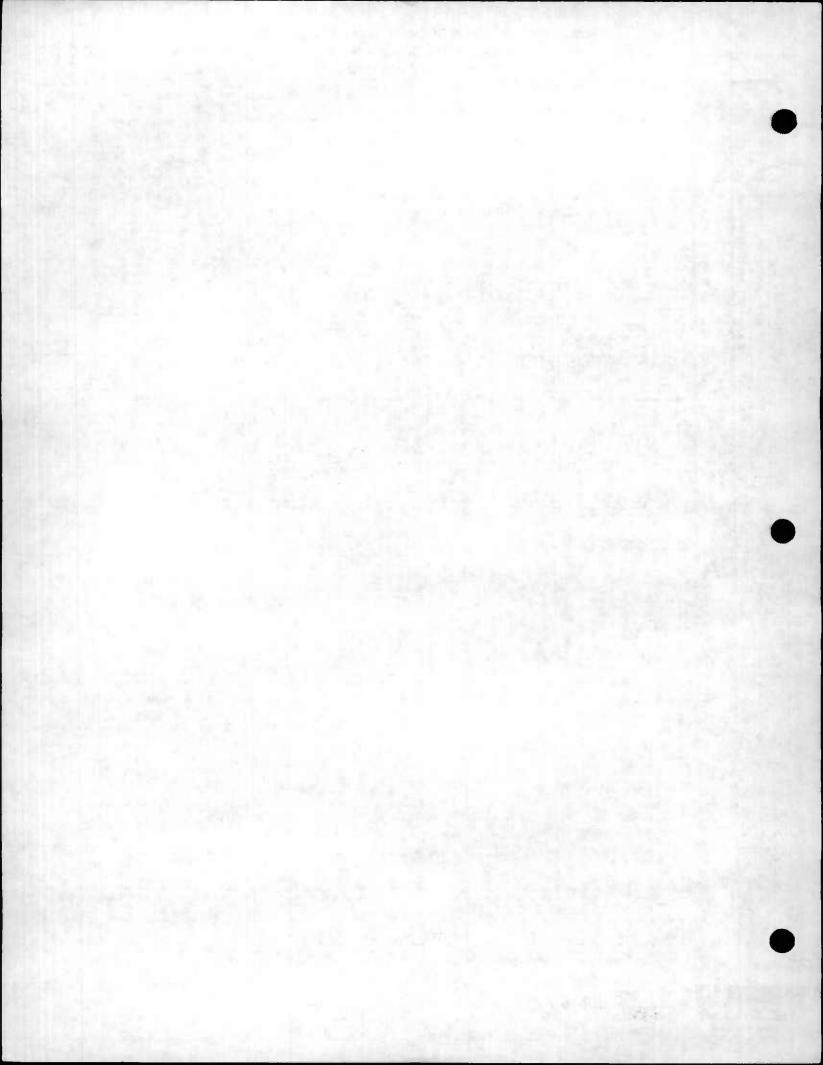


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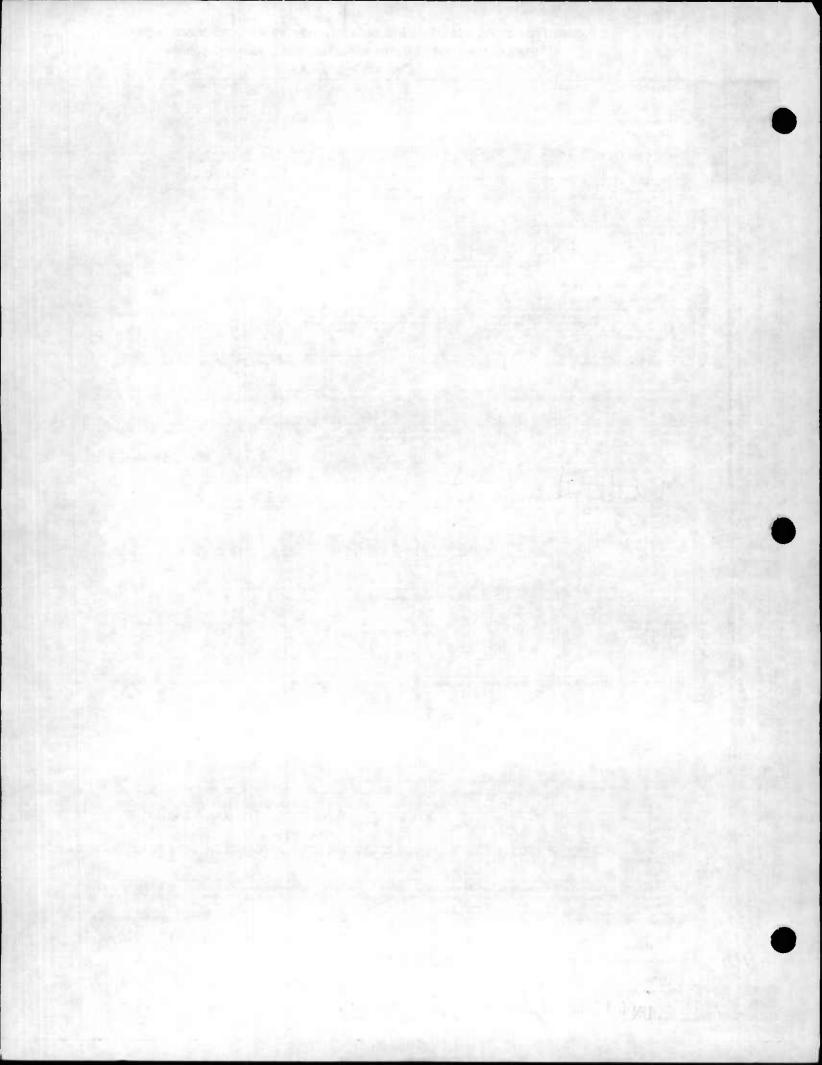
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				Ce	rtifica	te of	Death		Reg. No.		
an	1. Decedent's Nama (First, Middla,	Last)	1117					2. Date of Do	eath Day	Year	3. Tima of Death
	Ernest Alonza I	Layne						May	25. 2000		11:44 a.r
	4a Facility Nama (If not institution,	•					4b. City, Town, o	or Location of Dear			
	Doctor's Commun	-	:al				Lanham,		Prince	e Geor	
	5. Social Security Number  579-07-9090  Usual Residence of Decedent	6. Sax 1 M 2 □ F	Aga (In yrs. 83	last birthday) Yrs.	Months	Days		Feb. 5,	ay, Yeer)	9. Birthplac Country Virgi	ca (Stata or Foraign i) nia
	10a. Stata 10b. County	-2(I)-175	10c. Cit	ty, Town or Lo	ocation					10d	I. Inside City Limits
		George's	Riv	erdale		- 0- 1-			10- 03		tX Yas 2 No
	10e. Street and Number 4908 East West	Highway			20	)737			10g. Citizen of V		
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	Elemantary/Secondary (0-12)	Collega (1-40	or 5+)	Unava			during most of w		Federa	1 Gove	ernment
	17. Fathar's Nama (First, Middle, L.			10.24			18. Mothar's N	lame (First, Middle	a, Maidan Sumam	19)	WEIGHT.
	Maynard Aubrey	Layne					Iola M	lamie For	gueran		
	19a. Informant's Name/Ralationshi	ip (Type, Print)		19b. Maili	ng Addras	s (Street	and Number or	Rural Route Numb	per, City or Town,	Stata, Zip C	oda)
	Linda Lijewski  20a. Method of Disposition  1 Burial 2 Excremation  4 Donation 5 Other (Spe	3 □Removal from Stat	ta	4908 Placa of Disponentery, cra ropoli	osition (Na matory or	ma of othar pla	ce)	Data 5/26/00	20c. Location -	City or Towr	n, Stete
	Immediata Causa (Final disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in death) Last		Due to (c)  Dua to (c)		quence of	ren ::	monia	Jaspir		2	itarval Between brast and Daath
	Pert II. Other eignificant condition			ulting In the u	inderlying	causa gi	ven in Part I.	23b. Dic	l tobacco use co	ntributa to ti	he cause of death?
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	4 Homicida  detarmin  29a. Cartifiar (Check only 2 Medical E.	Physician: To the bed xaminer: On the basis and mannar	of axamina stated.	ition and/or in	iva stigetio	n, in my⊣ Эc. Lican	sa number	ccurred at the time	, date end place, 29d. Date signe	and due to the	ha causa(s)



		icate of D	eath	Reg. No.	3. Time of Death
Physician /Medical	1. Decedent's Name (First, Middle, Last) Roberta Lord		Mor May	of Death th Day 26, 2000	Year 5:50 P.M
Examiner	4e Facility Neme (If not institution, give street end number) 12517 Rockledge Drive		City, Town, or Location of Bowie		y of Death ce George's
Funeral Director	129 07 6781 1 M 2 F 90 Yrs. Mc	Under 1 Yeer onths Days	Hours Min. 8. Date (Mor	of Birth th, Pay, Year) 10, 1909	9. Birthplace (State or Foreign Country) Ireland
dand dand	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locatio	n		-	10d. fnside City Limits
th with the Marylar 23a or 28a-f show ant be notified at ai Director	Maryland Pricne George's Bowie				X⊠Yes 2□No
or 28		Of. Zip Code	-	10g. Citizen of	
uter death with the Maryland r frems 23s or 28s-f show that must be notified at Funeral Director	12517 Rockledge Drive  11. Manital Status 12. Was Decedent Ever in U.S. 13. Wes	2071			States
9 22 5	1 Never Merried 2 Merried 1 Yes 2 No		panic Origin? (Specify Yes Mexican, Puerto Rican, e Specify:	tc.) Bla	ck, White, etc.
72 hours natural;	15. Decedent's Education (Specify only highest grade completed) (Give kind	s Usual Occupati	ion rina most of workina	16b. Kind of B	Jusiness/Industry
led within 72 ho bygiene.  W. the Medical.  Completed	Elementary/Secondary (0-12) College (1-4or 5+) Manage		ring most of working	Cloth	ning Rental
Hed Hygie	17. Father's Name (First, Middle, Last)		8. Mother's Name (First, I		
fental H ked oth lic even	William Stewart		Margaret 0'	Mara	
nd 2 should be filed within all and Mental Hydiens. 27 is marked other than if traumatic event, the ITO Be Comp			nd Number or Rurel Route dge Drive Bo		
permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hyginard ment of Health and Mental Hyginard and Instituted other than "natural", or any injury or other traumatic event, in the constitution of the traumatic event, in the constitution of the traumatic event, in the constitution of the traumatic event, in the constitution of	20a. Method of Disposition  1⊠ Burial 2 □ Cremetion 3 □ Removal from State  4 □ Donetion 5 □ Other (Specify)  20b. Place of Disposition cemetery, cremetor Sacred Hea		May 30, 200 tery		- City or Town, State Maryland
Physician /Medical Examiner		000 Anna e mode of dying,	Evans Funora	1 Home, Ir wie Maryla alory arrest.	Approximate intervel Between Onset and Deeth
hat the death certificate be associated by the attending physician and setached for use as the burial-transit.  Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as e consequence or consequence				
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The law page 2			200	1□ Yes 2 12 No	1 Yes 2 No
yaician: The li yaician: The li s certificate ha director, page	25. Was cese referred to medicel axaminer?	- 1	26. Place of Death (Check	( only one)	
ng Phy fler thi neral	27. Menner of Deeth  1 12 Netural 5 Pending (Month, Dey Year) 2 Accident investigation		at 28d. De	scribe how injury occu	
din b	3 Suicide 4 Homicide determined 28e. Plece of Injury - At home, farm, street, building, etc. (Specify)		City	or Town, Stete)	
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the ta	29e. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occ only one)  Certifying Physicien: To the best of my knowledge, death occ on the basis of examination and/or investigant menner stated.				
To the vithing to the comp	29b. Signature and title of certifier MD	29c. License D 50	number 3 4 S		ed (Month, Dey, Year)
(5)	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print Kelvin Hao, MD 3231 Superior Lane, Ste	A-6	Bowie , Many	land 20%	715
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	back		1	

DHMH 16 Rev 6/95

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month. b. City, Town, or Location of Deeth 4e. Fecility Name (If not institution, give street end number 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs. 1 M 2 □ F Deys 36 629 Usuel Residence of Deceden 10d. Inside City Limits 10h County 10c. City, Town or Location 1 XYes 2 No Worcester Snow Hill 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 101 South Drive 21863 US 12. Wes Decedent Ever In U,S. Armed Forces? 1 Yes 2 Volo If Yes, Give 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. 1 Never Merried 2 Merried Specify: White 1 Yes 2 No Specify: Yeer or Detes: 3 XWidowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Supervisor Md.State Hgwy.Dept. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumame) Andrew Larson Nettie (not available) 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Barbara E. Timmons 101 South Drive, Snow Hill, Md. 21863 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State © Buriei 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Bates Methodist Cemetery 6-7-00 Snow Hill, Md. 22. Name end Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. aused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Intervel Between Onset and Deeth Immediate Cause (Fine) 2 mos diseese or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or as e consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No

**Physician** /Medical **Examiner** 

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 is marked other
any Injury or other traumatic avant

**Physician** 

/Medical

Examiner

10a State

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Director

Funeral

Completed by

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**Funeral** 

Director

filed within 72 hours after death with the Maryland Hygiene.

altimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Medical Examinal must be inclined as

burial-transit and attending physician for use as the buria the peed paga 2 director,

The law requires that the death certificate be executed signed by t has certificate or Attending Physician: this After death. Director: filled in by aftar 24 hours a the Hospital

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29c. License number 29d. Dete signed (Month. Dav. Year)

6-4-2000

Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

GREGORIO BELLOSO, M.D., 5302 CHINABERRY DRIVE; SALISBURY, MD

32. Registrer's Signature

31. Dete filed (Month, Day, Year)

JUN 0

29b. Signature and title of contifie

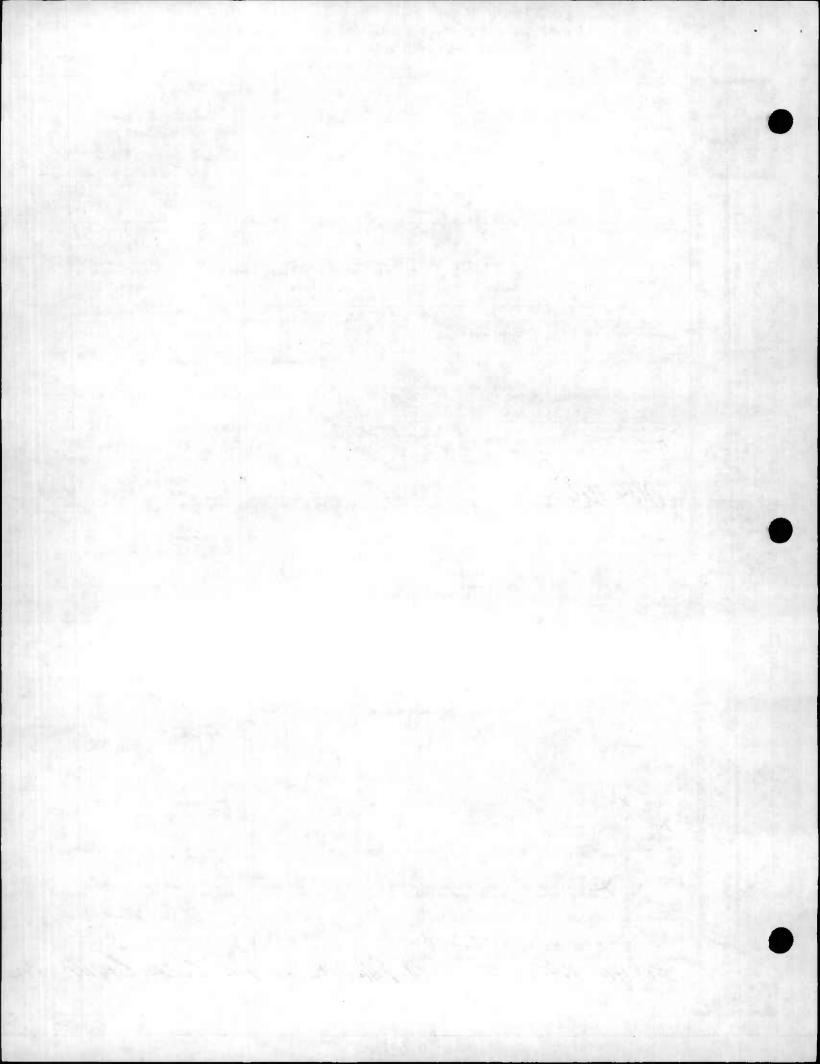
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Registrar

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State of Maryland / Department of Health and Mental Hygiene 00 19220

	Certificate	of Death	Re	g. No.			
Physician	1. Decedent's Name (First, Middle, Last)		2. Dete of Death Month	-	3. Time of Death		
/Medical	NICHOLAS A. LOTITO	T	6	4 2000			
Examiner	4a Facility Name (If not institution, give street and number) 701 BRADLEY RD.	OCEAN C					
Funeral Director	5//-4U-0139	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,	9. Birtl 1-15	hplace (State or Fore untry)		
28a-f ahow northed at rector	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location OCEAN CITY				10d. Inside City Lin		
a or 28e-f be notifi Directo	10e. Street and Number 10f. Zip C 21	842	10	0g. Citizen of What Co	untry?		
or items 23a or 28a-fa miner must be notelled Funeral Director	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No	ont of Hispanic Origin? (S) by Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	e, etc.		
- H 6	3 Wildowed 4 Divorced Year or Dates:	Occupation	. 1	Specify: WH	ITE		
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n 27 is marked on traumatic ever traumatic ever	19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (	Street and Number or Ru	ral Route Number,	City or Town, State, Z			
A Head	20e. Method of Disposition  20b. Place of Disposition (Name cemetery, crematory or oth	ner place)	Date 2	SILVER SP	Town, State		
Department of mportant: If any injury or acce.	21. Signature of Feneral Service Ligenage 22. Name end	VEN CEM.					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart tailure. List only one cause on each line.	H FUNERAL			. 21011		
ding physician and ise as the bural-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last  b. Due to (or as a consequence of):						
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is certificate director, pag To Be Co	25. Was case referred to medical examiner?	Othor	th (Check only one	-			
h. After this funeral di	27. Manner of Death  Natural 5 Pending  2 Natural 5 Pending  2 Natural 5 Pending  3 Sulcide 6 Could not be	c. fnjury at Work? 1 Yes 2 No	28d. Describe ho	nce 6 □Other (Spec ow injury occurred reet and Number or Ru			
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in 24 hou he Funer pletely fil edical	(Check only one) Medical Examiner: On the basis of examination end/or investigation, is and manner stated.	n my opinion, death occu	rred at the time, da	ate and place, and due	to the cause(s)		
To the comple	29b. Signafure and title of certifier 29c.	License number		9d. Date signed (Monti			
5	30. Name and address of person who completed cause of death (Item 23a) (Type, Prior)	ADELPHA .	AR. O.	6-5	4/1/2/8		
State Registrar	31. Date filed (Month, Day, Year) 32. Registrer's Signature	rocks					



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 221 Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** al /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea 4c. County of Death Examiner P.G. Ft. Wash. MD. Fort Washington Hospital If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 10/1/44 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Montha Days Hours 1□M 210 F Yrs. 180-36-2491 55 S.C. Usual Residenca of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. inside City Limits Ft. Washington 1 X Yes 2 □ No MD P.G. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 U.S.A. 13401 Pendleton St. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 20 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sec. Specialist Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leola Gardner unknown 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 13401 Pendleton St.Ft. Washington, MD. 20744 Beasley McIvey/husband 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 6/6/00 Clinton, Md. 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility Hodges and Edwards 3910 Silver Hill RD.Suitland, Md. 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, for heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth 23a. Part1 Immediate Ceuse (Finel MMA disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1□ Yes 2□No Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 DNatural 5 Pending injun 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) end menner es stated. Medical

requires that the death certificate be executed P.O. Box 68760 Division of Vital Records. or Attending Physician: efter death. Director: After this certifica Hospital 24 hours e Funeral D

**Funeral** 

Director

item 27 is marked other than "naturel", or items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or item any injury or other traumatic event, the Medical Exempton.

**Physician** /Medical

Examiner

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physician

3altimore, Maryland 21215-0020

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Registrar

(Check only one)

29b. Signature and title of certifier alle 0 29c. License number

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, dete end placa, and due to the ceuse(s) 29d, Data-signed (Morph, Day, Year) O

ind eddress of person who comp leted cause of death (Item 23a) (Type, Print)

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0 1 2000 31. Date filed (Month, Day,

32. Pegistrer's Signetu

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Physicia /Medic	al .		ETH McD	OWEL	L								2. Deta of D Month MAY	27	ay 7,200		4:55	A.M.
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit	To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or Injury thet Intileted events rasulting in death) Last  Due to (or es e consequence of):  d.																
death	sicia	Pert II. Other sig	nificant condi	tions con	tributing to d	eath bul	not resulting	in tha ur	nderlying o	euse giv	en in Pe	ort I.	23b. Die	tobacc	o use co	ntributs	to the caus	s of death?
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

**Physician** /Medical Examiner 3. Time of Death

**Funeral** 

Director

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Director

Funeral

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Completed

Be

filled within mit. Pages 1 and 2 should be fit partment of Health and Mental H portant: If Hem 27 is marked oth y Injury or other traumatic even

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

of Vital

Division

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**Physician** /Medical Examiner

Examiner Physician/Medical 946 þ Completed Certification: To Be ž After after death Director: 8 24 hours Medical

1. Decedent's Name (First, Middle, Last) 2. Data of Death Month 28 May 2000 4:15 P.M. Viola Katherine Marshall 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Pleasant Living Nursing Home Edgewater Anne Arundel 8. Data of Birth (Month, Day, Year) Sept. 10, 1905 Pennsylvania If Undar 24 Hrs. Hours Min. If Under 1 Yaar 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1□ M 10 F 94 218 56 7103 Yrs. Usual Rasidanca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Anne Arundel Harwood 1 Yas XINO Maryland 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zio Code 4744 K. Flanders Lane 20776 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ঐ No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 0 Homemaker Own Home 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) Mary (Unavailable) William Spalding 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 4745 E. Flanders Lane Harwood MD 20776 Samuel G. Steinour Son-In-Law 20b. Placa of Disposition (Nama of cematary, cramatory or other place) June 1, 2000 20a Method of Disposition 20c. Location - City or Town, Stata 1 Burlal 2 □ Cramation 3 □ Removal from Stata Fort Lincoln Cemetery Brentwood Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Robert E. Evans Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licensae 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or complications the caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heer fellure. List only one cause on each line. Approximate Intarval Batween Onset end Death Immediata Causa (Final disaasa or condition rasulting in daath) Dua to for as a consequence of) Sequentially list conditions, if any, laeding to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that Initiated evants resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Profile 24b. Wara sutopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Demontia 1 ☐ Yes 2 ₽No 1 Yas 2 No 25. Was casa rafarrad to medical examiner? 26. Pleca of Deeth (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) 1 Yas 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be determined 3 Suicide 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceusa(s) and mannar as stated.
2 Madical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and mannar stated. 29e. Certifier (Check only one) 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

To the P

1838 Greene

Rd / Suit 300/ Diremille, MD 21208

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MD

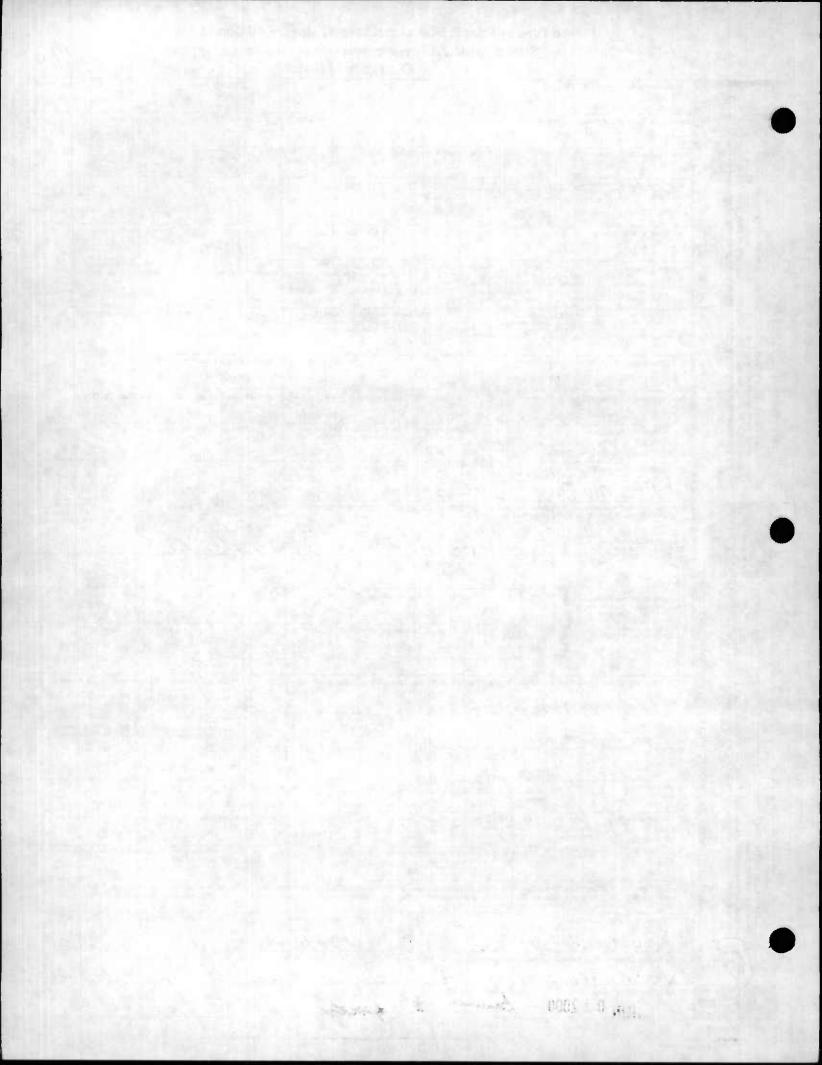
32 Registrer's Signatura

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

1 PWar

0 1 2000

acilini 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nema (First, Middle, Last) 3. Tima of Death **Physician** 120/pm MAY 25 2000 David Arabin McNamee /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital Lanham, Prince George's ff Under 1 Yaar 6. Sex 1 2 M 2 ☐ F 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Hours Months 75 Oct. 579-26-3216 16, 1924 Washington, DC Director Usuai Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits show 28a-f show 1 Yas 2 □ No Directo Maryland Prince George's Hyattsville 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 5 238 7021 Hunter Lane 20782 U.S.A. Funeral 12. Was Dacedant Evar In U,S. Armed Forces? 1 [XYes 2 □ No If Yes, Giva Yaar or Datas: WWII Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indien, 11. Marital Status Biack, Whita, etc. 1 Nevar Marriad 2 Married 6 1 ☐ Yas 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Coilega (1-4or 5+) Elementary/Secondary (0-12) Attorney Private Practice permit. Pages 1 and 2 should be fit.
Department of Heelih and Mental Hy
Important: If Nem 27 is marked othe
any Injury or other traument 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be Harry McNamee Katherine Arabin 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael A. McNamee - Son 2221 Dalewood Road, Lutherville, Maryland 21093 20e. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 5/27/2000 Alexandria, Virginia 21. Signatury of Funeral Service Licery 22. Nama and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avneue, Hyattsville, MD 20781 23a. Pert1. Entar tha disaase, or complications that cause the death shock, or heef failure. List only one cause on each line. Approximata Interval Between Onsat and Death be not antar tha moda of dying, such as cardiac or raspiratory arrast, **Physician** /Medical Immediate Cause (Final disaase or condition rasulting in daath) Examiner Physician/Medical Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, laeding to immadiata cause. Enter Underlying Causa (Disease or injury that initiated avants rasulting in daeth) Last Box 68760. the ! Due to (or as a consequence of): 88 980 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Nes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 s 1□ Yes 2NNo t □ Ves 2 □ No of Vital 25. Was case referred to friedical Medical Certification: To Be 26. Place of Death (Check only one) 20 No Hospitali 1 □ Inpatient 2 □ EP/Outpatient Other: 4□ Nursing Home 5□ Residence 6 □ Other (Specify) 1 Yes 3C DOA this 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 1 Natural funeral 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Division or Attending s sfler death.

I Director: Aft of in by the fur 1□ Yes 2□ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Hamicide To the Hospital or within 24 hours aft To the Funerel DI 1 Certifying Physician: To tha best of my knowledga, daeth occurred at tha tima, data and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daeth occurred at the tima, data and place, and due to the cause(s) and manner stated. 29a. Cartifian pletely 29b. Signature and titla of certifier 29c. Licensa number Data signed (Month, Day, Year) D05401 30. Name and addrass of person who complated causa death (Item 23a) (Type, Print) 1525 Greenway CTR Harding DR STE316 Green belt Md 20770 ames

**DHMH 16 Rev 6/95** 

State

Registrar

31. Data filed (Month, Day, Year)

MAY 3 0 2000

CNAMEE,

22. Registrar's Signatura

Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #26.Per Phys. PGC 5-30-2000 cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician DAISY V. May 2000 9:10 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4411 19th Avenue Temple Hills Prince George's If Under 1 Year 8. Date of Birth (Month, Day, Year) August 9,1923 N. Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2□NE 76 Yes Director 080 24 4063 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits worls 1 QYes 2 □ No pernit. Pages 1 and 2 should be filed within 72 hours after death with the Mi Department of Health and Mental Hyglane. Important: If itam 27 is marked other than "naturel", or hems 23s or 28s-4 in once. Director N. Carolina New Hanover Wilmington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4222 Fairlawn Drive 28405 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 Married 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify ģ 3 ☐ Widowed 4 ☐ Divorced Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Morris Mary Byrd Johnny 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4411 19th Avenue Temple HIlls, MD 20748 Lorenzo Morris (nephew) 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 31/00 torest 4 □ Donation 5 □ Other (Specify) Wilmington, N.C. 22. Name and Address of Fecility 21. Signature of Funeral Service Lice MARSHALL' S FUNERAL HOME OF MD usca low 4308 Suitland Road Suitland, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 01nos Examiner Due to (or as a consequence of): Examiner physician end s the burlal-transit The lew requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) ä signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 a 2DENO 1 ☐ Yes 2 ☐ No certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director, B 25. Was case referred to medical examiner? 26. Place of Death (Check only one) one) Nephew's Nephew's (Specify) Residence Hospital: 1 ☐ Inpetient Other: 4 ☐ Nursing Home -50 1 Yes 2000 2 2 ER/Outpatient 3 DOA 27. Manger of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 1/2/Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 8 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie (Check only On the basis of exa-and manner stated. mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and 1886 29c, License number 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 761

DHMH 16 Rev 6/95

State Registrar 3 0 2000

32. Registrar's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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1. Decedent's Name (First, Middle Gertrude	e, Last) T.		Newnan	n			2. Data of Do Month May		ð <b>6</b> 0	3. Time of Death 6:59A.M.
					4					orge!s
5. Social Security Number 579-01-7711	6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hr	8. Data of Bi (Month, D	rth ay, Year)	9. Birthp Cour	oleca (Stata or Foreign http) shington D
10a. State 10b. County	e George's				1				1	1 ☐ Yas 2 No
10e. Street and Number 5002 Meadowbi	rook Drive	9				6-3005		10g. Citizen of \	What Cour	
11. Marital Status  1 Never Married XX Marr  3 Widowed 4 Divorced	Armed For ied 1 ☐ Yes If Yes, Gi	rces? 2 XNo /a					Specify Yas or Norto Rican, etc.)		ck, White,	etc.
15. Decedent (Specify only highes Elementary/Secondary (0-12)	st grade completed)	I-4or 5+)	(Giva	kind of wo	rk done d	furing most of w	orking	C 279		dustry
									na)	
Harry G.  20a. Method of Disposition 1 N Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	Newnam  3 □ Removel from occity)	21616	5002 Place of Dispocemetery, crem Resurre	Meade sition (Narnetory or o	me of other pleasen. Cerud Address	ook Driv May metery sof Facility	ve Silve 30, 2000 Lee Fune	r Hill M 20c Location Clinto ral Home	D 20' City or To	746-3005 own, State aryland c. 20735
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c				HEA	HRT P	41LURG	DRY FAIL	URG	
Part II. Other significant condition	ns contributing to d	eath but not ra	sulting in the u	nderlying c	ausa give	en in Part I.		1 2 400	1.20/17	o the cause of death?
						1,34	24a. Wa	s an autopsy ormed?	av	ara autopsy findings ailable prior to implation of cause death?
25. Was case referred to medical				14		26. Place of D	1 □ seth (Check only		1[	Yas 2 No
examiner?		npatient 2 [ of Injury th, Day Year)	ER/Outpatien 28b. Tima of Injury	2	8c. Injury Work	4 □ Nursing / at (?	1	how injury occur		(y)
27. Manner of Death 1 DNatural 5 Pendin				M	1 1	Yes 2 No				
27. Manner of Death	not be 28a. Place	of Injury - At I ng, etc. (Spec	nome, farm, str ify)		, office	1169	28f. Location City or To	(Street and Numb own, Stata)	per or Rura	al Routa Number,
27. Manner of Death  1 Natural 5 Pendin  2 Accident investig  3 Suicide 6 Could r determined	pation not be ined 28a. Place building Physician: To the Examiner: On the b.	ng, etc. (Spec	ify) owledge, death	eet, factory	at the tim	ne, date and place	City or To	own, Stata) cause(s) and ma	anner as s	tated.
	Gertrude  4a Facility Name (If not institution Southern Mary.  5. Social Security Number  579-01-7711  Usual Residence of Decedent  10a. State 10b. County  Maryland Prince  10b. Street and Number  5002 Meadowbol  11. Marital Status  1 Never Married X Marrial Status  1 Never Married X Marrial Status  15. Decedent (Specify only higher Elementary Secondary (0-12)  17. Father's Nama (First, Middle, August P. Do  19a. Informant's Name/Relations Harry G.  20a. Method of Disposition  1 Donation 5 Other (S)  21. Signature of Funeral Service (Secondary Indicated Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	4a Facility Name (If not institution, give street and not Southern Maryland Hospits.)  5. Social Security Number	Gertrude T.  4a Facility Name (If not institution, give street and number) Southern Maryland Hospital  5. Social Security Number 6. Sex 7. Age (In yrs 579-01-7711  Usual Residence of Decedent  10a. State 10b. County 10c. Co. Co. Co. Co. Co. Co. Co. Co. Co. Co	Gertrude T. Newhar  4a Facility Name (If not institution, giva street and number) Southern Maryland Hospital  5. Social Security Number 6. Sex 1 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1	Gertrude T. Newnam  4e Facility Name (If not institution, give street and number) Southern Maryland Hospital  5. Social Security Number 6. Sex 579-01-7711 Usual Residence of Decedent 10e. State 10b. County Maryland Prince George's 10c. City, Town or Location 10c. State 10b. County Maryland Prince George's 5002 Meadowbrook Drive 11. Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 1 Never Married XIV Married 13 Widowed 4 Devorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) August P. Dorr  19e. Informant's Name/Fletationship (Type, Print) Harry G. Newnam 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name en 6633 (Constitution of the county in the initiated events resulting in death) Last Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of): 5 EVENT COPY Due to (or as a consequence of):	Gertrude T. Newnam  4a Facility Name (if not institution, give street and number) Southern Maryland Hospital  5. Social Security Number 6. Sex 1	Gertrude T. Newnam  4a Facility Name (if not institution, give street and number) Southern Maryland Hospital  5. Social Security Number 6. Sex 10 M 2 XF 81  7. Age (in yrs. lest birthday) Yrs. Months 10 Bays 10 Linder 1 Year 11 M 2 XF 81  10 C. City, Town or Location 10 State 10 Linder 24 Hr Months 10 Linder 1 Year 11 Linder 24 Hr Months 10 Linder 1 Year 11 Linder 24 Hr Months 10 Linder 1 Year 11 Linder 24 Hr Months 10 Linder 1 Year 11 Linder 24 Hr Months 10 Linder 1 Year 11 Linder 24 Hr Months 10 Linder 1 Year 11 Linder 24 Hr Months 10 Linder 1 Year 11 Linder 24 Hr Months 10 Linder 1 Year 11 Linder 24 Hr Months 10 Linder 1 Year 11 Linder 24 Hr Months 10 Linder 1 Year 11 Linder 1 Year 11 Linder 1 Year 12 Linder 2	Gertrude  T. Newnam    Ab. City, Town, or Location of Des Southern Maryland Hospital   4b. City, Town, or Location of Des Clinton	Gertrude T. Newnam    As Facility Name of find institution, pive street and number)   Southern Maryland Hospital   County Southern Maryland Hospital   County Southern Maryland Hospital   County Find Part   Gertrude T. Newnam  As Facility Name (if not institution, piva streat and number)  Southern Maryland Hospital  Social Security Number  Social Security Security Number  Social Security Security Number  Social Security Security Number  Social Security Security Security Security Number  Social Security Secur	

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State Registrar

31. Date filed (Month, Day, Year) MAY 3 1 2000

Maria Romero, M.D. 10403 Hospital Drive, #103, Clinton, Maryland 20735

Date filed (Month, Day, Year)

MAY 3 1 2000

MAY 3 2000

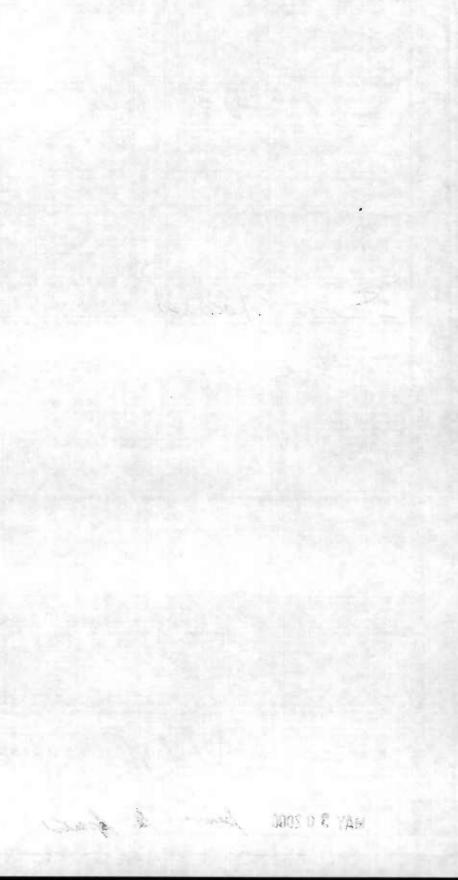
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00

19228

	Certificate of Dea	tt//	Reg. No.	
nysician	1. Decedent's Nama (First, Middle, Last) Virgil Henry Parker	2. Dete of Do Month May 22		3. Tima of Death 12:07 A.
Medical xaminer	4e Fecility Neme (If not institution, give street and number)  4b. City	y, Town, or Location of Deel		
	-0	•		
eral ctor	227-09-8728 XX 2 F 86 Yrs. Months Deys Hou	nder 24 Hrs. 8. Date of Bi urs Min. (Month, D March 2	9. Bir 25, 1914	thplece (State or Foreig buntry) Virginia
	Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limit:
6				1 ☐ Yes 2 ☐ N
Directo	Maryland Prince Georges Mt. Rainer  10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	Λ
	3815 31st Street 20712		U.S.A.	ounity?
Funeral		e Origin? (Specify Yes or N		erican Indian
E	11. Merital Sfetus  12. Wes Decedent Ever in U,S. Armed Forces?  1  Never Married  12. Merital Sfetus  13. Was Decedent of Hispanic If Yes, specify Cuban, Mexital State In Yes, Specify Cuban, Mexi	xican, Puerto Rican, etc.)	Bieck, Whit	te, etc.
þ	3 □ Widowed 4 □ Divorced Yeer or Detes:	ecify:	Specify: Whi	.te
	15. Decedent's Education 16a. Decedent's Usuel Occupation		16b. Kind of Business	/Industry
o Be Completed	(Specify only highest grade completed)  (Give kind of work done during tille. DO NOT use retired)  (Elementery/Secondery (0-12) College (1-4or 5+)	most of working		
E	12 Mechanical Contra	acting	Plumbing	
36.0		Nother's Name (First, Middle	and the second s	
0	Samuel Joseph Parker Co	ora Lucy Ma	rkham	
	19e. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street and No.			Zip Code)
	Margaret J. Parker/ Wife 3815 31st Street	t Mt. Rainer,	MD 20712	
	20e. Method of Disposition  20b. Piece of Disposition (Name of cemetery, cremetory or other place)	Dete	20c. Location - City or	Town, Stete
	MXBuriel 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Ft. Lincoln Cemetery	May 25, 200	O Brentwood	, MD
1	21. Separature of Funeral Service Licensee 22. Name end Address of Fu	ecility Ft. Linco	ln Funeral	Home
	3401 Bladensbu			
	23a. Part I. Enter the greese, or complications that caused the deeth. Do not enter the mode of dying, such shock or hear in fre. List only one cause on each line.			Approximate
n	andox, or read there. List only one cause on eech line.			Interval Between Onset and Deeth
al	Immediate Cause (Finel	.1 Di		
1	disease or condition resulting in deeth)  Atherosclerotic Cardiovascu	ular Disease		<u> </u>
ě	Due to (or es a consequenca of):  Severe Anemia			
Examiner	b			
Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events  Due to (or es a consequenca of):  Due to (or es a consequenca of):			
edical	Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of):			
Pe	leading in deem) Last			
an/M	d			1
10	Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in P	Pert I. 23b. Did	tobacco uae contribute	to the cause of deal
Physicia	Prostate cancer	10	Yes 2♥ No 3□P	robably 4 Unknown
by				
3			s en eutopsy 24b.	Were eutopsy finding eveilable prior fo
Completed			111111111111111111111111111111111111111	completion of causa of death?
6		10	Yes ZX No	1 Yes 2 No
BeC	25. Was case refarred to medical 26. F	Place of Deeth (Check only	one)	
ToB	axeminer? XX Hospital:	□ Nursing Home 5 □ Res		ecify)
	27. Menner of Death 28a. Dete of Injury 28b. Time of 28c. Injury et		how injury occurred	
atio	1 Naturel 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes:	2 No		
110	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - Af home, farm, streef, fectory, offica building, etc. (Specify)	28f. Location	(Street and Number or Rown, State)	lurel Route Number,
ert	4 ☐ Homlcide building, efc. (Specify)	Chy or 70	own, State)	
edical Certification:	29a. Certifier (Check only   Medical Examiner: On the basis of exemination and/or investigation, in my opinion,			
Med	one) and manner steted.  29b. Signeture end fitte of certifier 29c. License numl	ther	29d. Date signed (Mon	th Day Year)
	29b. Signeture end fittle of certifier  29c. License numb  0.3 9.3		5-23	
	1 2 July 1 3 7 3		2-23	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		20706	
	George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. #I	Lanham, MD	20/06	
State	31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture			
strar	MAY 3 0 2000 Serve S. Darle			



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Month GRACE DOROTHY QUIGLEY 2000 1406 6 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 10 F Yrs. 099-22-3924 70 5/25/30 Massachusetts Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 252 Teal Circle 21811 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14 Raca - American Indian 11. Marital Status Biack, White, etc. 1 ☐ Yes 2 No If Yes, Giva Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 5 Registered Nurse Hospital 18. Mother's Name (First, Middle, Malden Surneme) 17. Fathar's Nama (First, Middla, Last) Olavf Dittrich Dorothy Oakman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 252 Teal Circle Ocean Pines, MD Thomas Quigley/ Husband 21811 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 20 Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crematory 6/7/00 Frankford, DE A Survice Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 ☐ Yas 2 ☐ No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3□ DOA 27. Manger of Death 28c. tnjury et Work? 28d. Describe how injury occurred 28b. Time of 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2/ Accident 6 Could not be determined 28f. Location (Straet and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide

physician and is the burial-transit The law requires that the death certificate be executed P.O. Box 68760, attending p signed by the a Division of Vital Records, been sig s certificate hes director, page 2 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

P

Physician/Medical Examiner

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Completed

Be

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Certification:

Medical

29a. Certifier

29b. Signature an

31. Dete filed Mo

oth. Day.

JUN 0 6

funeral

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
shit: If termine 72 is a marked other than "nature!", or fame 23s or 23s-f show un; If termine 73s or 23s-f show ury or other traumatic event, if a Medical Experiment must be notified at

Important: If It any injury or o

Physician

/Medical Examiner

Department

tey, Grace 5/25/30- 6/4/00

Buigh

Maryland 21215-0020

Baltimore,

á To the Hospital or A within 24 hours after To the Funerel Direcompletely filled in b

State

Registrar

30. Name and ad 23a) (Type Print)

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medicat Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d, Date signed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Daeth Month **Physician** Edward Thomas Robinson, Sr. 1:25 AM JUNE /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Hospital Lanham Prince George's If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth OCLODET 7, 1928 9. Birthplace (State or Foreign Washington, D.C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 15 M 2□ F 71 Yrs. 578-30-5844 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits XX Yes 2 No Prince George's Director Maryland Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2435 Kent Village Place 20785 United States of America Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 11. Meritel Stetus 1 ☐ Never Merried 2 ☐ Married Yes 2 No if Yes, Give Year or Detes: 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th grade National Capitol Housing Plumber Baltimore, Maryland

Colmit. Pages 1 and 2 should be fise
Opportment of Health and Marital Hy
Important if New 27 is marked oth
any injury or other traumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Anna Charity 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John E. Robinson, Sr. (Son) 4431 Comwall Court Upper Marlboro, Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place)

National Harmony Memorial Park 6/7/2000 Landover, Maryland 20a. Method of Disposition 20c. Location - City or Town, Stete 1 □ Burial 2 □ Cremation 3 □ Removei from Stete 4 □ Conation 5 □ Other (Specify) 21. Signature of Funeral Service License me end Address of Fecility
ROLLINS FUNERAL HOME, INC. 4339 HINT PLACE, N.E. WASHINGTON, D.C. 20019 23a. Puril. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, mosk, of heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Physician/Medical Examiner arkersenie Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) unlime - annaxo Due to (or es a consequenca of): Pert II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown menuel þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? B 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 5 Pending investigation 1 Neturel To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fun 1 TYes 2 TNo 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760. Attending Physician:

> State Registrar

**DHMH 16 Rev 6/95** 

31. Dete filed (Month, Day, Year) JUN 0 2 2000

29b. Signature and title of certifier

29e. Certifier

(Check only one)

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

9450 Pann. Ave. #18 Upper Merboro, MD 20172 32. Registrer's Signeture

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

D20824

29d. Date signed (Month, Dey, Year)

State of Maryland / Department of Health and Mental Hygiene 00 19231

sician ledical					Cel	unca	te of l	Dealli			Reg. No.		
ledical	1. Decedent's Nam				X III					2. Date of D Month MAY	eath Day 200	Year	3. Time of Deeth 12:00 PM
	AGNES	M ROPE		um <i>ber)</i>			4	lb. City, To	wn, or L	Dia I		nty of Death	12:00 PN
miner		IST HEALT								PARK	MO	NTGOME	RY
	5. Sociel Security to 241-46-8		Sex 1□ M 2⊠ F	7. Age (In yrs	. last birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	6. Data of B	irth Year 29	9. Birth Cou	place (State or Foreign ntry)
r	Usuel Residence of			/	J 114.					O D D D	., 1727	Nort	h Carolina
	10a. State	10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
Director	Maryland	Montgom	ery	Si	lver Sp	1		150					1 □ Yes ATTNO
	10e. Streef and Nu 8107 E.a.	mber stern Av	e. # D3	07		10f, Zi	p Code	910			10g. Citizan e U . S		ntry?
Funeral	11. Merifat Status	Beelin iiv	12. Wes De	cedent Ever in	U,S. 13.	Was Dece			gin? (Sp	ecity Yes or N Rican, etc.)		ace - Amari	
by	1 ☐ Never Man	ried 2 Married	Armed F 1 Yes If Yes, G Year or	2∕QNo ive				Specify:	n, Puerto	Rican, etc.)		lack, Whita, city: B1a	
Completed	(Spe	15. Decedent's E	ducation ada complated	)	16a. Dece (Giva lifa.	dent's Usu kind of w	ual Occup	ation during mos	t of work	ring	16b. Kind of	Business/In	ndustry
mp	Elementary/Second 1.2	ondary (0-12)	College	(1-4or 5+)	Child						Day C		
ပိ	17. Father's Name	(First, Middle, Las	t)		Onlin	Cale	give		er's Nam	e (First, Middle	Day Ca e, Maiden Sum		
To Be	Garret	t Yourse						Anni	.e ]	Bell			
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		□Cramation 3		Stata	Ptace of Dispo cemetery, cres	matory or	other plac			Date	20c. Locatio		
	4 ☐ Donation	5 Other (Spec	-	Ft.	Linco			ry ss of Facilit			00 Brei		
Suc	13	A Service Lice	5						Ft.		1n Fune		
	23a. Part1. Enter	the disease or cor	molications that	caused the de							wood, N	ID 207	Approximate
Wedical Examiner	Sequentially list or if any, leading to if cause. Enter Und Causa (Disease of that initiated event resulting in death)	onditions, nmediate erlying i injury s Last	c		or as a consector as a consec								
3			l d						711				
by Physicia	Part II. Other signi	ficant conditions	confributing to	death but not re	sulting in the u	ndarlying	cause giv	en in Part I		23b. Die			to the cause of death
Y Ph										10	Yes ZAN	o 3□Pro	bably 4 Unknow
Completed by										24a. Wa	s an autopsy formad?	8'	Vara autopsy findings vaitable prior to ompletion of cause I daath?
Сомр										10	Yes 2XX	1	☐ Yas 2☐ No
BeC	25. Was case refe	rred to medical						26. Place	of Dea	th (Check only	one)		
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on:	27. Manner of Dear	5 Pending		e of Injury nth, Day Year)	28b. Tima o Injury		28c. Injur Wor		Ale	28d. Dascribe	how injury oc	curred	
Certification:	2 ☐ Accident 3 ☐ Suicide	investigation 6 □ Could not	be one plan	a of Injury - At	home farm str	M facto		Yes 2□	NO	28f. Location	(Street and Nu	mber or Ru	ral Route Number,
E T	4  Homicida	datarmine	buik	ding, atc. (Spec	ify)	1001, 10010	,,				own, State)		
0	29a. Certifier (Check only one)	XIX Certifying P 2☐ Medical Exa	miner: On the	e best of my kr basis of examir nner stated.	owledge, deatletion and/or in	h occurred vestigatio	d at tha tin n, in my o	na, data sn pinion, des	d place, th occur	and dua to the	a cause(s) and o, date and place	mannar as e, end due	stated. to the cause(s)
dicai			0			29	c. Licens	e number			29d. Date sig	ned (Month	, Day, Year)
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Medical	29b. Signature end	stille of certifier	Hon	n			D203	62			May 30	,2000	1.7.75
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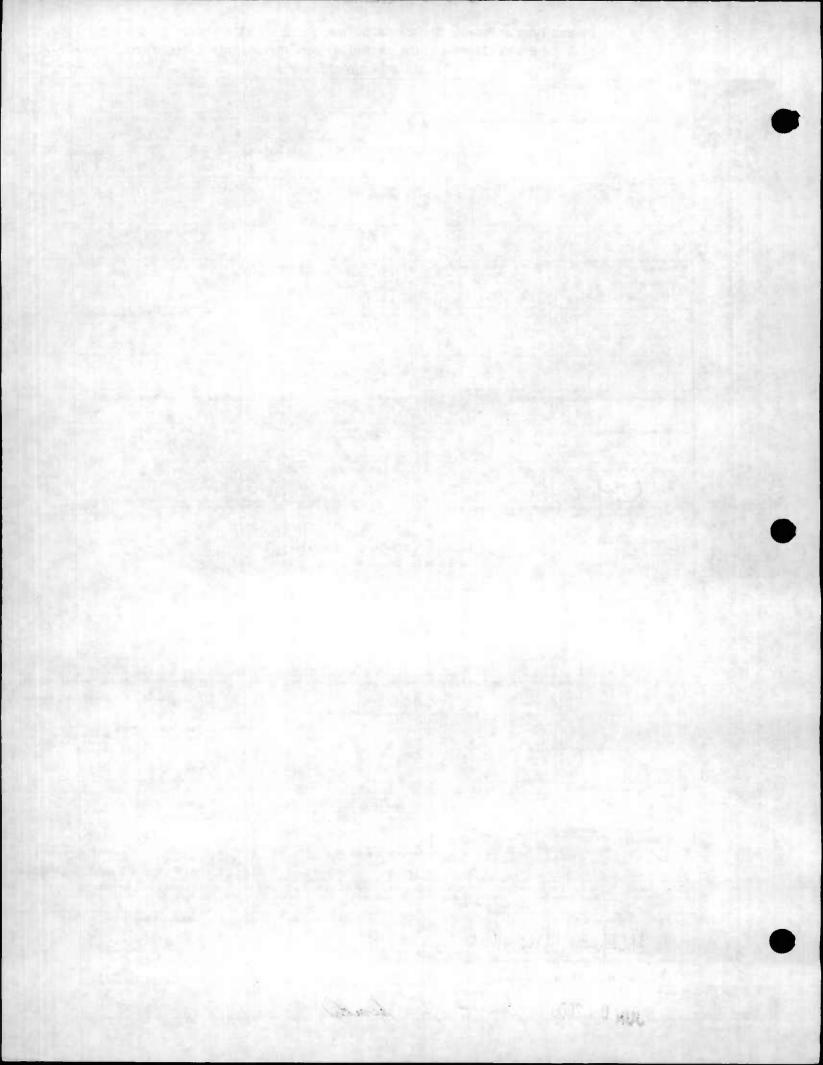
hysician /Medical xaminer  neral ector	1. Decedent's Nama (First, Middle,  4a Facility Name (If not institution,						2. Dete of D	Triangle I		3. Time of Death
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_	578-16-4834	S. Sex 1□ M 2☑ F	7. Age (fn yrs. las		Months Deys	Hours Min.	8. Dete of 8 (Month D April	17, 1914	Country Wash	ington,
6 44	Usual Residence of Decedent  10e. Stete 10b. County	1 1-2018 B	10c. City,	Town or Local	tion				100	l. Inside City Lin
D 0	Maryland Prince	George's	Tem	ple Hi	11s					1□Yes 2∏
1 V -	10e. Street and Number				10f. Zip Code	100 40 15		10g. Citizen of W	hat Country	17
	4215 24th Ave.			4	20748			USA		
T Be	11. Marital Status 1 ☐ Never Merried 2 ☐ Marrie	12. Wes Dece Armed For 1 Tes If Yes, Giv	dent Ever in U,S. rces?		s Decedent of H es, specify Cube	lispanic Origin? (Sp en, Mexicen, Puerto Specify:	ecify Yas or N Ricen, etc.)	Bieci	- Americer k, White, etc	
d by	3 Widowed 4 □ Divorced	Year or Da	ates:				V-			
t, the Medical	15. Decedent's (Specify only highest	Education grada completed)		16e. Deceden	nt's Usuel Occup	etion during most of work d)	ing	16b. Kind of Bu	sinass/Indu	stry
d w	Elementery/Secondery (0-12) 8th	Collega (1	-4or 5+)		lerk	"		Federal	Gove	rnment
Be Co	17. Fathar's Name (First, Middle, Li	nst)				18. Mothar's Nam	a (First, Middl	a, Maidan Sumama	a.)	
0 80 a	Francis E. Ward					Mary C.	Sheehe	ey		
au I	19e, Informent's Neme/Reletionshi	p (Type, Print)				and Number or Rur				
*	Bernadette Warre	n/Daughte	er			Brook W	ay Uppe	er Marlbo	ro, M	d. 2077
	20a. Method of Disposition  XXBuriel 2 ☐ Cremation 3		20b. Pied	ce of Dispositi netery, cremat	ion (Neme of tory or other plea	ce)	Data	20c. Location - (	City or Town	n, Stete
i i	4 Donetion 5 Other (Spe		Resi	urrect	ion Ceme	etery 6/	6/2000	Clinton	, Mar	yland
P S S	21. Signeture of Funarel Sarvice Li	censee			lame end Addre	ss of Fecility Kalas Fu	noral F	Homo P A		
	AM P. K.	she !	),			Hill Rd.				5
	23e. Pa/11. Enter the diseese for coshock, or heert failure. Vist or	omplications that can't one cause on e	sed the death. ech line.	Do not enter	the mode of dyir	ng, such es cardiac	or respiretory	errest,	A	pproximete itervel Between
cian l	Immediate Course (Final									enset and Death
1 0	Immediete Ceuse (Finel disease or condition resulting in deeth)	aCar	diopulmo						W	eeks
ē 1		0		s e conseque	nce of):				37	
Examiner	Conventinity list conditions	b. Caro	liomyopa	thy s e conseque	nce off:		-		Y	ear
the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	Core	onary Art						Y	ears
the bu	thet initiated evants	c		s a conseque						
	resulting in death) Last									
for use as		<b>d</b> ,								
Physician/M	Part II. Other significant condition	contributing to de	eth but not resulti	ing in the unde	ertying ceuse giv	en in Pert I.	23b. Die	d tobacco uas con	tributs to t	3737
Ph.							10	Yss 2□ No	3 Probe	bly 4∰Unki
should be detached							24a Wa	s an eutopsy	24b. Were	autopsy findin
Completed							per	formed?	evail	able prior to pletion of causa
3 E								Yas 2 No	of de	
Be Co	25. Was case referred to medical					26. Place of Deal			10	Yes 2□ No
. = 0	examiner?	Hospital:	npatient 2 EF	P/Outpation!	3D DOA Oth	or.	200	sidence 6 🖾 Otha	r (Snacify)	Daughte
	27. Menner of Deeth	28a. Dete d	of Injury 2	8b. Time of	28c. Injur			how injury occurr		Resid
the funeral	1 Neturel 5 ☐ Pending investige		h, Dey Year)	Injury		Yes 2 □ No				
> =	3 ☐ Suicide 6 ☐ Could no determin	t be ed 28e. Plece	of Injury - At hom- ng, etc. (Specify)	e, ferm, street	t, factory, office		28f. Location City or T	(Street end Numbe	er or Rurel I	Route Number,
filled in by		Julian	igi oto. (Opecny)				5.3/ 5. 1	., -,-,-,		
edical						ne, date and plece, pinion, deeth occur				
	one)	and mann	ner steted.	The state of the s	E TOTAL PROPERTY.	pinion, deeth occur				
₩ 2	29b. Signature and title of certifier	011	/	100	29c. Licens	e number		29d. Date signed	(Morith, Di	(y, Year)
7) L	last	5 h	NOS	141	J D0641	19		June 2	, 200	)
) 3	James P. Jarboe				To a second	Hollywoo		2000		

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State of Maryland / Department of Health and Mental Hygiene 00 19233

			0011		Death		Reg. No.		2600
	1. Decedent'a Neme (First, Middle, La	st)				2. Dete of D			3. Tima of Death
cian	GERALD L.	STEVENSON, I	II			Month MAY	27	2000	18:01 PM
lical iner	4a Facility Name (If not Institution, giv	re street end number)			4b. City, Town, o			ty of Deeth	20102 211
	4021 34th STREET				MT. R	AINIER	PRT	NCE G	EORGE'S
1	5. Social Security Number 6. S	Sex 7. Age (In yrs. la	sf birthday)	If Under 1 Year	If Under 24 H	s. 8. Date of B			plece (Stete or Foreign
	574-15-6343	IM 2□ F 16	Yrs.	Months Days	Hours Mi	6-19-	99, <i>Year</i> ) 83	Wash	nington DC
	Usual Residence of Decedent								
26	10a. State 10b. County	10c. City,	Town or Loc	ation				1	0d. Inside City Limits
to	MD Prince	George's Mt	. Rai	nier					XXYes 2□No
Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of	f What Cour	ntry?
	4301 Kaywood D	r. #5		207	12		Unite	d Sta	tes
Funeral	11. Marital Status	12. Was Decedent Ever in U,S	. 13. W	as Decedent of	Hispanic Origin?	Specify Yes or N		aca - Americ	
5	1√2 Never Married 2 Merried	Armed Forces? 1 ☐ Yes ②☐No			oan, Mexican, Pue	erto Hican, etc.)		ack, White,	
2	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	□ Yes XXNo	Specify:		Spec	ity: Bla	ick
	15. Decedent's Ed	ducation	16a. Decede	ent's Usual Occu	pation	erest and	16b. Kind of	Business/Inc	dustry
name di vino	(Specify only highest gra		(Give k	ind of work done O NOT use retire	during most of w	orking	PT SINE		
	11th	College (1-4or 5+)	Stud	ent			Sc	hoo1	
ľ	17. Father's Name (First, Middle, Last)	)			18. Mother's N	eme (First, Middl	e, Meiden Sume	me)	
000	Gerald L. Stev	enson, Sr.			Chery	lene W	hitfie	1d	
ŀ	19a. Informant'a Name/Reletionship (		19b. Mailing	Address (Stree	at end Number or				Code)
	Cherylene Roll								
ŀ	20a. Method of Disposition	20b. Pia	ca of Dispos	ition (Neme of		Date	20c. Location		
	N☐ Burial 2 ☐ Cremation 3 ☐			etory or other pla		6/2/200	n Clint	on M.	d
-	4 □ Donation 5 □ Other (Specif				metery		1		
	21. Signetum Funeral Service Licer		22 R	alph W	iullian	s Fune	ral Se	rvice	
1	/ (alph 6)	Velleaus 767	7 5	17 11t	h St.,	SE, Wa	sh., D	C 200	003
edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Olsease or Injury that initiated events resulting in death) Last	C	as a consequ		8				
	L	d.	ting in the up	dochring cause of	han in Rod I	22h Di	d tobacco use c		o the cause of death?
	Part II. Other eignificant conditions of	contributing to death out not result	ung in the un	deriyirig cadse g	Well III Fall I.		Yee 25 No		bably 4 Unknown
						- 1	_ 100 _ 20 100		
l						240 18/0	s en eutopsy	av	ere autopsy findings ailable prior to impletion of cause
							tomed?	of	death?
						per	Tes 2□No	of	death? Yes 2□ No
	25. Was case referred to medical				26 Place of F	per 1 C	Yes 2□No	of	/
	25. Was case referred to medical examiner?	Hospital:	DiOute alian	3 COA 0	Man	per 1 C	Yes 2□No	of	Yes 20 No
	25. Was case referred to medical examiner? 1 [X] yes 2 □ No 27. Manner of Death	1 □ Inpatient 2 □ E	R/Outpetient	3LI DOA	ther: 4 Nursing	per 1 Check only 1 Home 5 Re	Yes 2□No	of 11	Yes 20 No
	examiner?  1 X Yes 2 No  27. Manner of Death 1 Netural 5 Pending	28a. Date of Injury (Month, Day Year)		28c. Inju	ther: 4 Nursing	per 1 Check only 1 Home 5 Re 28d. Describ	y one) sidenca 6XX e how injury occ	of 11 other (Special curred	Yes 20 No
	examiner?  1 X yes 2 No  27. Manner of Death  1 Neturai 5 Pending 2 Accident investigetion 3 Stiicide 6 Could not b	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Inju	ther: 4 Nursing	per 1 Check only Home 5 Re 28d. Describ	Yes 2 No yone) sidenca 6XX s how injury occ	of 1ther (Special curred of 5 5)	Syes 20 No  Sy) SCENE
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	examiner?  1	28a. Date of Injury - At hon building, etc. (Specify)	28b. Tima of Injury 18:01 ne, farm, stre	28c. Inju	ther: 4 Nursing ury et ork? Yes 2 No	per 10 10 10 10 10 10 10 10 10 10 10 10 10	one) sidenca 6XX show injury occ the how injury occ the work of the company of the company occurs. (Street and Nur own, Stere) 344837	of 18 other (Special curred of 5 5 1) other or Rural PRAN	Yes 2 No  Y) SCENE  AOY  el Route Number, UN  Lo GEORGEO
	examiner?  1 X Yes 2 No  27. Manner of Death 1 Neturai 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28a. Date of finjury (Month, Day Year)  28e. Placa of Injury - At hon building, etc. (Specify)  29e. Placa of Injury - At hon building etc. (Specify)  29e. Placa of Injury - At hon building etc. (Specify)	28b. Tima of Injury 18-01 ne, farm, stre	28c. Inju W 10 et, factory, office	ther: 4 Nursing	per 10 10 10 10 10 10 10 10 10 10 10 10 10	Sidenca 6XX e how injury occ  Star Who (Street and Nur own, Stete) 3 4 1 8 7 e cause(s) and i	of 18 other (Special curred of S S S S S S S S S S S S S S S S S S	Syes 20 No  SCENE  AOY  BI Route Number, UM  Lo Georges Contacted.
	examiner?  1 X Yes 2 No  27. Manner of Death 1 Neturai 5 Pending investigetion 3 Sticide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Examples	28e. Placa of Injury - At hon building, etc. (Specify)  1981can: To the best of my know	28b. Tima of Injury 18-01 ne, farm, stre	28c. tnj W 10 et, factory, offica occurred at the estigation, in my	ther: 4 Nursing Livet ork? Yes 2 No  lime, date and pla opinion, death oc	per 10 10 10 10 10 10 10 10 10 10 10 10 10	Sidenca 6XX e how injury occ (Street and Nur own, Stete) 3 4 4 3 3 e cause(s) and i	of 18 menner as see, and due to	Syes 2 No  Sy) SCENE  ACY  Pl Route Number, Wy  Lo (Lough)  Stated.  o the cause(s)
	examiner?  1 X Yes 2 No  27. Manner of Death 1 Neturai 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28a. Date of finjury (Month, Day Year)  28e. Placa of Injury - At hon building, etc. (Specify)  29e. Placa of Injury - At hon building etc. (Specify)  29e. Placa of Injury - At hon building etc. (Specify)	28b. Tima of Injury 18-01 ne, farm, stre	28c. tnj W 10 et, factory, offica occurred at the estigation, in my	ther: 4 Nursing	per 10 10 10 10 10 10 10 10 10 10 10 10 10	Sidenca 6XX e how injury occ  Star Who (Street and Nur own, Stete) 3 4 1 8 7 e cause(s) and i	of 18 menner as see, and due to	Syes 2 No  Sy) SCENE  ACY  Pl Route Number, Wy  Lo (Lough)  Stated.  o the cause(s)
edical Certification: 10 Be Completed by	examiner?  1 X Yes 2 No  27. Manner of Death 1 Neturai 5 Pending investigetion 3 Sticide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Examples	28a. Date of finjury (Month, Day Year)  28e. Placa of Injury - At hon building, etc. (Specify)  29e. Placa of Injury - At hon building etc. (Specify)  29e. Placa of Injury - At hon building etc. (Specify)	28b. Tima of Injury 18-01 ne, farm, stre	28c. Inju et, factory, office occurred at the estigation, in my 29c. Licer	ther: 4 Nursing Livet ork? Yes 2 No  lime, date and pla opinion, death oc	per 10 10 10 10 10 10 10 10 10 10 10 10 10	Sidenca 6XX e how injury occ (Street and Nur own, Stete) 3 4 5 8 7 e cause(s) and it e, date and place	of 18 menner as see, and due to	Syes 2 No  Sy) SCENE  ACY  Pol Roure Number, Wy  Let Georges Costated.  o the cause(s)  Dey, Year)
Medical Certification: To Be Completed by Physician	examiner?  1 X Yes 2 No  27. Manner of Death 1 Neturai 5 Pending investigetion 3 Sticide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Examples	28a. Date of injury 28a. Date of injury 28a. Date of injury 28a. Date of injury 28a. Date of injury 38a. D	28b. Tima of Injury  1 8-0 Ine, farm, stre	28c. Inju et, factory, office occurred at the lestigation, in my 29c. Licer	ther: 4 Nursing Ury et ork? Yes 2 No	per 10 10 10 10 10 10 10 10 10 10 10 10 10	Sidenca 6XX e how injury occ (Street and Nur own, Stete) 3 4 5 8 7 e cause(s) and it e, date and place	of 18 other (Special curred of 18 other or Rum  Property of Rum  Property	Syes 2 No  Sy) SCENE  ACY  Pol Roure Number, Wy  Let Georges Costated.  o the cause(s)  Dey, Year)
edical Certification: To Be Completed by	examiner?  1 X Yes 2 No  27. Manner of Death 1 Neturai 5 Pending investigation 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of Injury 28a. Date of Injury 28a. Date of Injury 28a. Date of Injury 38a. D	28b. Tima of Injury  1 8-0 Ine, farm, stre  2 47 ledge, death on and/or Inventor Inven	28c. Inju et, factory, office occurred at the toestigation, in my 29c. Licer	ther: 4 Nursing Ury et ork? Yes 2 No	Peeth (Check only) Home 5 Re 28d. Describ Substitute State S	sidenca 6XX e how injury occ from the first and Nur own, Stere) g um 8 7 e cause(s) and in e, date and place 29d. Date sign	of 18 menner as se, and due to med (Month, 28, 20	Yes 2 No  Yes 2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Year **Physician** May 11:31AM 30, 2000 Benjamin Stone Joseph /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) **Examiner** 5410 Temple Hill Road Temple Hills Prince George's If Under 1 Yeer | If Under 24 Hra. 8. Dete of Birth (Months | Days | Hours | Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** MM 20 F Director March 11, 199-26-3778 Usual Residence of Decede 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits tal Hygiana. Id other than "nature", or liems 23a or 28a-1 show event, the Medical Examiner must be notified at the Maryl 1 ☐ Yes 2X No Directo Temple Hills Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20748 Funeral 5410 Temple Hill Road 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black White etc. filed within 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 12th N/A Shop Steward Commercial Roofing 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 2 should be fi and Mental F is marked of 8 permit. Pages 1 and 2 should be Department of Health and Menta Important: If frem 27 is married any injury or other traumatic evants. Philip V. Stone M. Sabalusky Mary 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 9112 Midland Turn Upper Marlboro, Maryland20772 Earl Stone (Son) June 3 Dete 2000 20c. Location - City or Town, State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 1 ➡ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Resurrection Cemetery Lee Funeral Home, Inc. 22. Name end Address of Facility 21. Signeture of Funeral Service License 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heer feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) artery oronury Examiner Due to (or as a consequence of) Physician/Medical Examiner pertension sician and bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): attending physician for use as the buria Box 68760 Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records, þ

Completed Ber Certification: To

To the Hospital or Attanding Physicien: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag

edicai State Registrar

24e. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? 2 No 1 Yes 25. Wes case referred to medice! 26. Piece of Deeth (Check only one) Hospitel: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 1 Natural 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1XX certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated. 29e. Certifier

29d. Dete signed (Month, Dev. Year)

6/1100

29c. License number 29b. Signature and tille of certifie MD 31077 MD gahumay

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 7801 Old Branch Ave. #409 Clinton, Md. 20735

Ali Rahimian, M.D.

31. Date filed (Month,

0"1"2000 JUN

32 Registrer's Signeture south

The second secon

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** William M. 723 Snowden, Jr. 2000 MA /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) County of Death Examiner AMP SPENGS
If Under 24 Hrs. 8. Date of PRINCE GERRES MALCOLM GIROW HOSPITAL AFB If Under 1 Yeer Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□ F 53 577-62-4854 Director 01-22-47. Washington, D.C. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ♥ Yes 2 No Md. Prince Georges Suitland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 23s or 20746 U. S. A. 4158 Suitland Road Funeral 14. Rece - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus permit. Pages 1 and 2 should be fised within 72 hours after a Department of Health and Mental Hygierie.

Broportant: If them 27 is marked other than "natural" or any injury or other traumatic event. 1 Tes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Electrician 12th U.S. Government 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Edith Anderson William M. Snowden, Sr. 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Wauline C. Snowden 4158 Suitland Road Suitland, Md. 20746 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☐ Burlei 2 ☐ Cremetion 3 ☐ Removel from State Northern Virginia Crematory 6/2/00 Arlington, Va. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
W. H. Bacon Funeral Home, Inc. 21. Signeture of Funerel Service Licensee 3447 14th St., N.W. Washington, D.C. 20010 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heer feilure. List only one cause on each line. Approximate Intervei Between Onset end Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical . HYPERTENSIVE CARDIOVASCULAR DISEASE MID Examiner RENAL FAILURE CHRANK Physician/Medical Examiner iding physician and ise as the buriaf-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of) P.O. Box 68760, that initieted events resulting in death) Last Due to (or es a consequence of): Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown signed b Records, þ Completed 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of deeth? page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital I or Attending Physician: after death. Director: After this certifica Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? 5 Panding 1 Neturel 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homlcide 24 hours after Funeral Dire letely filled in t Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signatur 29c. License numbe 29d. Dete signed (Month, Dey, Year) influented 23a) (Type, Print) 30. Neme and address of person who complet CM 3 1 2000 32. Registrer's Signeture 31. Dete filed (Month, State Registrar

DHMH 16 Bay 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Stoll Mary Α. Month Day **Physician** 29 2000 3:45 PM May /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Mariner Health Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 7 19 5. Social Security Number Sex 1 M 2 F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Yrs Director 438-34-4835 Usual Residence of Decedent April 1928 Louisiana with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ntal Hygiene. ed other than "natural", or Nema 23a or 28a-f ahov event, the Medical Examinar must be notified at 1∏Yes 2□No Director Maryland Prince Georges Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 U.S.A. 9789 Good Luck Rd. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas X M No If Yes, Givê Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, apecify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status filed within 72 hours efter 1 Never Married 2 MMarried Specify: White 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Creative Design 0 Bookkeeper Baitimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other treumatic event, place. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Joseph Bailev Unk. P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9789 Good Luck Rd. Seabrook, Maryland 20706 Lawrence W. Stoll II (Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/2/00 Metropolitan Crematory Alexandria, Virginia 22. Name and Address of Facility
Rendon/Hale Funeral Home 21. Signature of Funeral Service Licenses 9013 Annapolis Rd. Lanham, Maryland 20706 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner 11berc sician and burial-transit The law requires that the death certificeta be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated eventa resulting in death) Last to (or as a consequence of): P.O. Box 68760. physician s the buria Due to (or as a consequence of): Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown ate has been signed by page 2 should be detact Records, þ Completed 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an eutopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 8 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 Ho this 28a. Date of Injury (Month, Day Year) Ne Hospital or Attending Ph n 24 hours after death. Ne Funeral Director; After th 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. To the To the To the F 29b. Signeture and title globitifie 29d. Date signed (Month, Day, Year) dress of person who completed cause of death (frem 23a) (Type, Print) 13614 avako 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 3 0 2000 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Yea Month MA-**Physician** 10:41AM 2000 Audrey Fance Sago /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's er If Under 24 Hrs. ys Hours Min. 5. Social Security Number If Under 1 Ye 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 25 F Yrs. Director 233-10-7790 88 July 21, 1911 NC Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Show ms 23a or 28a-f short must be notified at 1₩ Yes 2□No Funeral Director Prince George's Cottage City 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 20722 U.S.A. 4110 Cottage Terrace Herne 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Specify: White 1 Yes 2 No Specify: by 3 € Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 pounit Papes 1 and 2 should be file Department of Health and Mental Hy important if flem 27 is marked other any Injury or other \*\*\* 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Unavailable Unavailable 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4110 Cottage Terrace, Cottage City, MD Joan R. Sago-Daughter 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other piece, 20c. Location - City or Town, State Date NESSurial 2 Cremetion 3 Pegeoval from State 4 □ Donation, 5 □ Other (Specify 5/30/00 Brentwood, MD Lincoln Cemetery 21. Signature of Funeral Se 22. Name end Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final epticemia disease or condition resulting in death) Examiner Physician/Medical Examiner 15cus The law requires that the death certificate be executed Sequentietly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Box 68760 the Due to (or es a consequenca of) for use as 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown & Filrellooms Records, Completed by 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? page 2 certificate has 1 🗆 Yes 2 No of Vital Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitat: 1 Sinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this funerai 27. Manner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? After 1 Qatural Division or Attending 5 Pending investigation I hours after death. uneral Director: Ah ely filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Momicide To the Hospital o within 24 hours at To the Funeral Di critifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated.

Con the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature au us of certifier D16410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 7500 HANGVER AHRKWAY STELDS GREENBELT, MD 20170 GABRIEL JAFFE 31. Dete filed (Month, Day, Year) State MAY 3 0 2000 Registrar

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Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, To the Hospital within 24 hours a To the Funeral Completely filled

**DHMH 16 Rev 6/95** 

State Registrar (Check only one)

29b. Signature and title of certifie

MAY 302 Bay Year)

JACK M.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

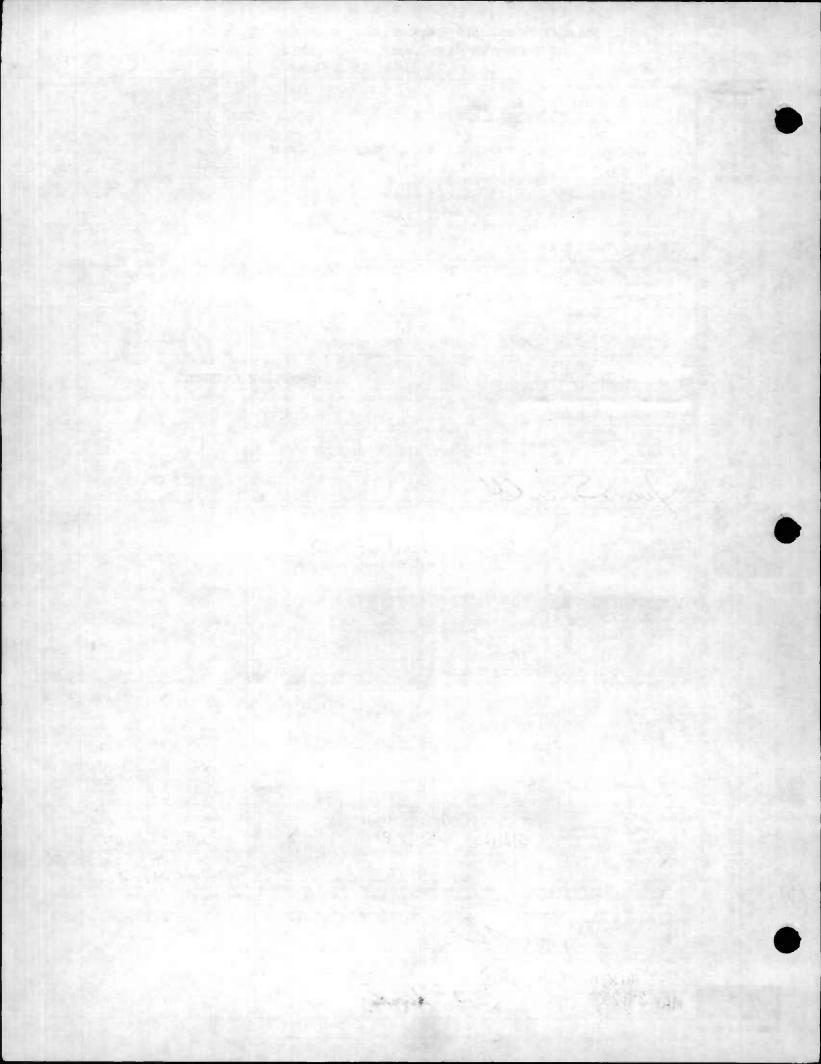
29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

May 22, 2000



### Please Type or Print in Black Indelible ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Deeth 2. Date of Death **Physician** 2000 MAY Charles L. Stancliff 24 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Doctors Community Hospital Lanham Ir If Undar 24 Hrs. Prince Georges If Under 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Davs Hours Min. 10XM 20 F Yrs. Director 82 577-05-9515 1917 Maryland Usual Rasidanca of Dacedeni with the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 XYas 2 No Director 28a-f Maryland Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 6 23€ 5603 Lanham Station Road 20706 Funeral United States America 12. Was Decedant Evar in U,S. Armed Forcas? Herma 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, Whita, atc. 1 ☐ Yas 2 ☐kNo If Yas, Give 1 ☐ Navar Married 2 1 Married ò Specity: White 1 Yes 2 XNo Specify: 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Be Completed 18a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Hygiene. Elamentary/Secondery (0-12) Collega (1-4or 5+) 12 Hardware Store Owner permit. Peges 1 and 2 should be flik Department of Health end Mental Hy Important: If them 27 is marked other eny Injury or other traumatic avant 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surneme) Charles A. Stancliff Violet M. Bright 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) Carolyn C. Stancliff/Spouse 5603 Lanham Station Road, Lanham, MD 20706 Saltimore. 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20a Mathod of Disposition Data 20c. Location - City or Town, Steta 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Ramovel from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 5/27/2000 Brentwood, Maryland 22. Nama and Addrass of Facility Fort Lincoln Funeral Home 21. Signeture of Funaral Sarvice Licensas 3401 Bladensburg Road, Brentwood, Maryland 20722 23a. Part1. Entar tha diseese, or complications that causad tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Interval Between Onsat and Daath Physician /Medical Immediate Cause (Finel disaasa or condition rasulting in daath) Examiner Examiner chi a Nigene The lew requires that the death certificate be executed **burial-transit** Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or injury that initiated avants resulting In daeth) Last Dua to (or as a consequence of): Box 68760. physician by Physician/Medical as the L Dua to (or es e consaquenca of): for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 TYSS 2 No Records, Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of deeth? 1 Yes DNO 1 ☐ Yas 2 ☐ No of Vital Physician: 25. Was casa referred to medical axaminar? Certification: To Be 26. Placa of Daath (Check only ona) 1 Yas 2 No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this Inneral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? After t 1 Haturel 5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

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within 24 hours a Hospital completely 6

> State Registrar

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31. Data filed (Month, Day, Year)
MAY 3 0 2000

to complated causa of death (Item 23a) (Type, Print)

32 Registrar's Signatura

Licansa number

226

29d. Data signed (Month, Day, Year)

Medicat Exampler: On the bast of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

20 Medicat Exampler: On the basts of axamination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner steted.

Physician	PART 1. Decedent's Name (First, Middle			84 Oei	tificate of	Death	2	2. Date of De Month Mav	Day	3. Time of Death 000 6:58 P.M
/Medical Examiner	4a Facility Name (If not institution							ation of Deat	h 4c. Count	ty of Deeth
Funeral Director	Prince George 5. Social Security Number 214-48-7404		. Age (In yrs. I		If Under 1 Yea Months Deys		Min.	B. Date of Bir (Month, Da June 4	th ay, Year)	9. Birthplece (State or Foreig Country) Maryland
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after death with the Maryla or items 23s or 28s-f sho miner must be notified at it Funeral Director	10e. Street and Number 6213 L Stree	t			10f. Zip Code 2074	3		1		What Country? States Of Ameri
D E	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed For	ZE No		Was Decedent of I Yes, specify Cu I ☐ Yes 2 No		in? (Spec Puerto Ri	ify Yes or No ican, etc.)	Speci	ice - American Indian, ack, White, etc. Black
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/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a		EROTIC as a conseq	CARDIO	VASCUL	AR DI	SEASE		

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Medical Certification: To Be Completed by Physician/Medical Exami

Division of Vital Records, P.O. Box 68760.

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examiner? x1√2¥es 2□ No	Hospital: 1 Inpatient 25	RP/Outpatient 30	DOA	Other: 4 Nursing I	Home 5□ Res	idence 6 🗆 Ot	ther (Specify)
7. Manner of Death  1 ⊠Natural 5 □ Pending 2 □ Accident investigat		28b. Time of Injury M	28c.	Injury at Work? 1 Yes 2 No	28d. Describe	how injury occu	rred
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29a. Certifier	
(Check or	)
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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piaca, and due to the cause(s) and manner as stated.

2 XIII editor: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end piace, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Patush ,	A Nadano

O.C.M.E

June 01,2000

Of America

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S, 19 31. Date filed (Month, Day, Year) JUN 0 9 2000

111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrar's Signature

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Physician	Decedent's Neme (First, Middle, La     T. C.P.C.		T-1-	100			2. Deta of Dee Month	Dey	3. Time of Deeth
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uneral rector		1⊠M 2□F	01	Yrs. Mont	hs Deys	Hours Min.	(Month, De)		El Salvador
led at	10e. State 10b. County Md. Prince G	Georges	10c. City, Town	or Location					10d. Insida City Lim 1 ☑ Yes 2 ☐ 1
at be notified	10e. Street and Number 2611 Nicholson	Street	Apt. 3	10f.	Zip Code	0782		10g. Citizen of V El Sal	
Examiner must	11. Meritel Stetus  1 X Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1  Yes 2 X N If Yes, Give Year or Detas:				tispanic Origin? (Spe an, Mexican, Puerto I Specify: £1 Sa			e - American Indien, k, White, etc. : Hispanic
t, the Medical	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	16a.	Decedent's L (Give kind of life. DO NO Labor	Isuel Occup work done Tusa retire	etlon duning most of workir d)	ng .	16b. Kind of Bu	nstruction
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ury or oth	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremetion 3 ☐  4 ☐ Donation 5 ☐ Other (Specif			Disposition ( y, crametory amily (	or othar ple		Dete 6-17-20		City or Town, Stete azan, El Salv
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director, page 2	25. Wes case referred to medical					26. Place of Deeth	(Check only o	ne)	1
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To the Funeral Director: Atlant completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not b 4 Homicide determined	Zoe. Plece of inju	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)				28f. Location (S City or Tox		er or Rurel Route Number,
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- 1									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** 2000 0221 FLORENCE E SMITH

4a Facility Name (If not institution, give street and number) JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO H Under 24 Hrs. 8. Date of Birth Month, Day, Year) 04/12/1910 If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1□M 25 F Days 212-18-6327 90 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 Yes 2 No Director or 28a-f MD Worcester Pocomoke City 10e. Street and Number 10g. Citizen of What Country? 238 1006 Cedar Street 21851 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married b Maryland 21215-0020 1 Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machine operator Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be next of Health and Mental Jerry William Hart Flissie Gibbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23417 mportant: If Ihem 27 any injury or other to Helen Mears/ Cousin 250070 Nancock Gardens Rd. Onancock, Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pitts Creek Presb. Cem 6/3/00 Pocomoke City, MD 21. Signature of Funegal Service Licensee 22. Name and Address of Facility Holloway Melson Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21851 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Minit Asysth Examiner Due to (or as a consequence of): Physician/Medical Examiner Anh or Attending Physician: The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Atrial Fibrillation 1 Yes 2 No 3 Probably 4 ☐ Unknown Division of Vital Records. Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? Surere Chami Obstractor Pelyman Desease 24a. Was an autopsy performed? Premone 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 20 No 26. Piace of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier PJOPPC 6.1.00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBUTY, MO Circlerella M.S. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 02

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

9243 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Vesi Physician Alice Ellen Sharpley 2352 3 2000 TUNE /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Deys Hours 1□M 2X F Director 214-28-7997 7/31/1908 Maryland Usual Residence of Deceden with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits ahow "natural", or items 23a or 28a-f ahor 1 ☐ Yes 2 No Maryland Worcester Stockton Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 6136 George Island Landing Road 21864 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. filed within 72 hours after I □ Yes 27 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 8 Housewife Homemaker permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy important: If Itam 27 ia marked other any Injury or other traumatic. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John Elliott Annie Ouillen 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Harvey Lynch - Son 6 - 14th Street, Pocomoke, MD 21851 20b. Piece of Disposition (Neme of 20c. Location - City or Town, Stete 20a Method of Disposition cemetery, crematory or other place)
Taylorville Churchyard 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 6/6/00 Berlin, MD 21811 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 108 William Street The Burbage Funeral Home Berlin, MD 21811 23e. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause of each line. Approximate Intervsi Between Onset and Death **Physician** /Medical Immediate Cause (Final Ja hrs Due to (or es e consequence of): diseese or condition resulting in deeth) Examiner Examiner 0. 1 dastice Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Csuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): pug Box 68760, Due (of es e consequence of): 29.00 Physician/Medical signed by the a 23b. Dfd tobacco usa contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by of Vital Records, 24b. Were autopsy findings available prior to 24a. Was sn sutopsy performed? peen completion of cause of death? has 1 ☐ Yes 2 10 No 1 ☐ Yes 2 ☐ No this certificate or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No funeral 27 Menner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Affer Division 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 4 hours after death-uneral Director: A the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, streef, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral C Medical 29e. Certifier 1 Contrying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as atsted. completely 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date and place, and due to the csuse(s) and menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 00 Jander, D. O 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Salohy mp 2184 Permenden D. 12c 120.0 n

Registrar

State

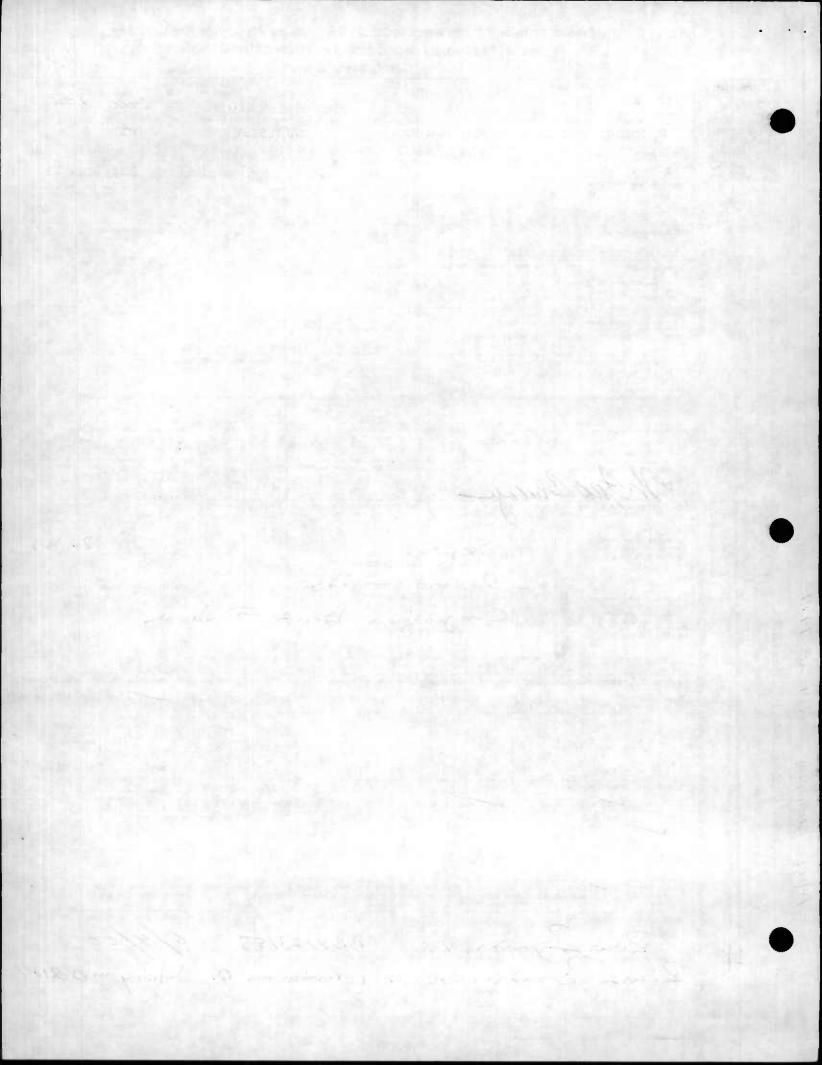
31. Dete tiled (Month, Dey, Year)

JUN 0 5 200

214-28-7997

SHARPLY

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 19244 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Year **Physician** 31 HERMAN CARROLL 1220 SMITH JR. 2000 May /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5. Social Security Number If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days Months Hours Yrs. 67 Director 212-30-5332 07/17/32 VIRGINIA Usual Rasidance of Dacedan 10a. Stata 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Director VIRGINIA **ACCOMACK** PARKSLEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 24160 WHITE ST. 23421 U.S.A. 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Give 11. Marital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, Whita, etc. 1 Never Merried 2 Married r than "natural", or the Medical Exami 1 Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Yaar or Datas: Be Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC 10 AUTOMOTIVE 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Pages 1 and 2 should be nent of Health and Mental HERMAN CARROLL MARGARET ENNIS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) RUBY ANNIS SMITH/WIFF 24160 WHITE ST., PARKSLEY. VA. 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 6/3/00 ONANCOCK CEMETERY ONANCOCK, VIRGINIA 21. Signature of Fonaral Sarvica Licenses 22. Nama and Address of Facility WILLIAMS-ONANCOCK FUNERAL HOME 94 MARKET ST., ONANCOCK, VIRGINIA 23417 23a. Part. Entar tha disease, or complications that caused the deeth. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, nock, or haart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence ot): Physician/Medical Examiner Preymonia The law requires that the death certificate be executed lician and burial-trans Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or injury that initiated events rasulting In death) Last Dua to (or as a consequenca of): Box 68760. Dua to (or as a consequence of): Dr Jon Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1⊠Yes 2□ No 3□ Probably 4□ Unknown Colonia Division of Vital Records. à

Be Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, t 2 edical Certification:

termon smith

24a. Was an autopsy 1 Yes 2 XNo

24b. Ware autopsy tindings available prior to completion of cause of death?

26. Place of Death (Che

1 ☐ Yas 2 ☐ No

CK Only Onej	
Residence	6 □Other

1 □ Yes 2 📆 🗗		Hospital: 1 Inpetient 2	ER/Outpatient	3□	DOA Other:	Nursing	Homa 5 ☐ Residence 6 ☐ Other (Specify)
2□ Accident	5 Panding invastigation		28b. Tima of Injury	М	28c. Injury at Work?		28d. Describe how injury occurred
3 Suicida 6 Could not be 4 Homicida datarmined	28a. Placa of Injury - At h building, atc. (Speci	ioma, farm, stree fy)	t, fact	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a.	Cartifier
	(Check only
	one)

25. Was casa ratarrad to medical

29b. Signature and titla of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

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	n who complated causa of death (Item 23a) (Type, Print)

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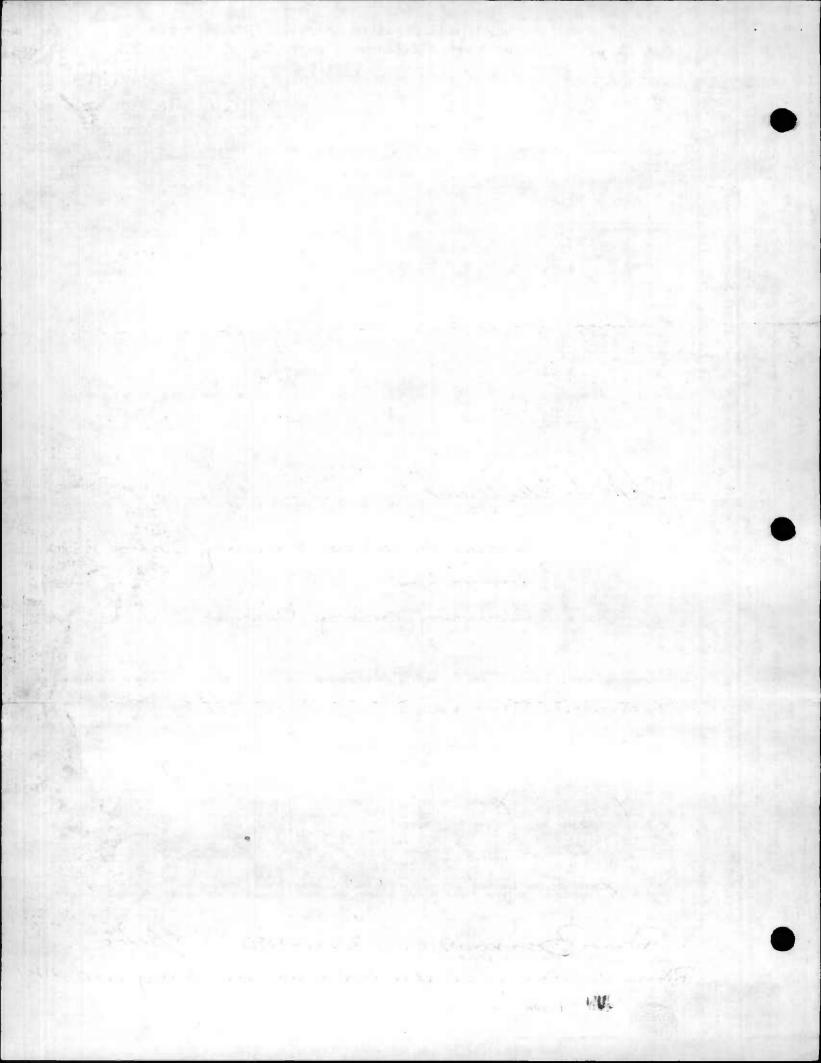
29d. Data signed (Month, Day, Year)

State Registrar

31. Data filed (Month, Day, Year) JUN 0 7 2000

1D.a. 1201 32 Registrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9245 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year Physician Allan C. Trafton mac 28 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Community Hospital Lanham Doctors # Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XMM 2DF 062 24 7351 76 Director Aug. 26,1923 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show X Yes 2□No Maryland Prince George's Funeral Directo Bowie 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Items 23s or 12108 Wilmont Turn 20715 United States 14. Race - American Indian, Biack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 KRes 2 □ No If Yes, Give Yeer or Detes: 1 Never Married 25 Married 1 Yes 2₺ No Specify: White à Specify: 3 Widowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 Bus Driver Trailways 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If hem 27 is marked oth any injury or other traumatic event Be Clifford Trafton Elsie Aufderheide 19a. Informant's Name/Relationship (Type, Pnint) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Anne M. Trafton Wife 12108 Wilmont Turn Bowie Maryland 20715 Saltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) June 2, Date 2000 20a. Method of Disposition 20c. Location - City or Town, Stete to Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Crownsville Maryland 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Robert E. Evans Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 5 dz4 Meumon, a disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner Acmie cholocyst. t. ) The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760, **Ittending physician** Vrosep SIS Due to (or as e consequence of): and chance renol failure P.0. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 11/2/e, mer, Discore Records, þ 24a. Was an autopsy performed? 24b. Were eutopsy findings svallable prior to completion of cause of death? Completed certificata has 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vitai al or Attending Physician: T s after death. Il Director: After this certificat ed in by the funeral director, p 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 MInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 ANatural 2 Accident Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, offica building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) end manner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a, Certifier

State Registrar

29b. Signature and title of cartifier

31. Dete filed (Month, Day, Year)

Roger

2094B.

B.

0 1 2000

30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

Adm Inh

32 Registrer's Signeture

29c. License number

D05891

Ingham 6510 Kenilworth Avenue Riverdale, Maryland

29d. Date signed (Month, Day, Year)

5/28/6

egs to mit

# Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Cei	rtificate of	Death		F	leg. No.		9240		
Physician	1. Decedent's Nama (First, Middle, La						2. Data of Dea Month	-	Year	3. Time of Deeth		
Physician /Medical	John A. Thomas					MAY		00	0100 AM			
Examiner	4a Facility Nama (If not institution, giv				4b. City, To	wn, or L	ocation of Death	4c. Count	y of Death	-00-1		
70	5. Social Security Number 6. S		211/5	If Under 1 Year	UPPE	TK I	MAKLBOW	DI PRIN	08 61	eyets		
Funeral Director		ex 7. Age (In yrs. 73	Yrs.	Months Days	Hours	Min.	6. Data of Birth (Month, Day Nov. 28	,1926	Coun	lace (State or Foreign itry) ington D.C.		
pu Mand	10a. State 10b. County	10c. City	y, Town or Lo	cation					1	0d. Inside City Limits		
Many franch tor	Maryland Prince George's Upper Marlboro							1 ☐ Yas X ⊠ No				
vith the Ms or 28a-f	10e. Street and Number 10f. Zip Code						1	Og. Citizen of	What Coun	itry?		
23e	3111 Merrydale D		20772			Unite	d Sta	tes				
5-0020 72 hours after death with the Maryland natural; or theme 23e or 28e-f show alter Exercitive must be notified at	11. Marital Status  XXX Nevar Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Agried Forces? 1 1 1 2 No If Yes, Give Year or Datas:	mmed Forces?  ☐Yas 2☐No Yes, Give 1				pecify Yes or No- o Rican, etc.)  14. Race - American Indian, Black, White, atc.  Specify: White			atc.		
	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	life. DO NOT use retired)			ing	16b. Kind of Business/Industry					
	10	0	Prin	ter				Print				
be flied other event.	17. Father's Nama (First, Middle, Last)						a (First, Middle,		me)			
should be unarked of u	Frank G. Thomas		1				Foster					
M2 and 2 19a. Informent's Neme/Ralationship ( Elaine G. Stone	Type, Print) Friend		Merryda.									
m 0	20a. Mathod of Disposition 1 ☐ Buriat 2☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Removal from Stata	emetery, cren	sition (Name of matory or other pla t Cremato		ne 2	2000	20c. Location Waldo:				
permit. Page Department of Important: If any Injury or	21. Signature of Funeral Service Licen	Bir On	) R	Name and Address bert E.	Evans	Fur				715		
	23a. Part1. Entar tha disease, or comshock, or heart tailure. List only	plications that laused the death							1d 20	Approximata Interval Batween		
ficate be executed physician and is the buriel-transit edical Examiner	diseasa or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	b	r as a conseq	uence of):	047			1/15EA				
2 0 0	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d											
. 0 . 2 -	Part II. Other significant conditions of	ontributing to death but not resu	liting in the ur	nderlying cause gi	ven in Part	1.	23b. Did to	becco use co	ontribute to	The cause of death?		
that the detache						1 Yes 2 No 3 Probably 4			bably 4 Unknown			
requires							24a. Was a perfor	n autopsy med?	COI	ere autopsy findings allable prior to mpletion of cause death?		
The law are has the page 2 s							10Y	es 2000	10	Yas 2□ No		
ysician: The list certificate he director, page	25. Was casa referred to medical 26. Place of Deeth (Check only one)											
Physician: r this certific and director,	1 Vas 2 No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Ott	ner: 4□ Ni	ursing Ho	ma 513 Resid	ence 6 DOt	her (Specif)	y)		
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To the Hospital or Attending Phwithin 24 hours elter death. To the Funesel Director: After the completely filled in by the funesal Medical Certification:	2 Accident invastigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, stre		Yes 2		28f. Location (S City or Town		ber or Rura	l Route Number,		
To the Hospital or within 24 hours efter To the Funeral Dir completely filled in Medical Cert	29a. Cartifier (Check only one)  1 Certifying Physics Cartifier 2 Medical Example 1	rsician: To the best of my know iner: On the basis of examinat and manner stated.	vledge, death jon and/or inv	occurred at the tirestigation, in my o	me, date an opinion, dea	d place, th occurr	and due to the cred at the time, d	ause(s) and m ate and place,	anner as st and due to	ated. tha cause(s)		
To the virthing of the the comp	29b. Signature and title of certifier	WELL	14	29c. Licens	2291	124	2	9d. Data signe	28	20.		
10/1Va	30. Name and address of person who a	completed cause of death (Item	36) (Type, i	.1 0	TAL	DRI	VÉ . (	HOVER	LY N	10785 MARYLAND		
State Registrar	31. Data filed (Month, Day, Year) JUN 0 1 2000	32 Registrar's Signal		bood	,	1			1	7 -19		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev **Physician** Edward J. Turner 5 28 2000 2:30p.m. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital P.G. Clinton If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□ F Yrs. Director 578-88-4244 Wash. D.C. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 N Yes 2 No Director MD P.G. Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? from 23a or 8 9211 Stewart Lane 20735 U.S.A. Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ \$7es 2 □ No 6 / 4 3 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Merital Status pemilt. Peges 1 and 2 should be filed within 72 hours after d Department of Health and Mentel hyglene. Important: If item 27 is marked other than "natural", or item eny injury or other treumatic event, the Medical Examples. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2□ No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 3/46 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 1 2 College (1-4or 5+) Truck Driver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown Hazel Parker 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lillian Marbury/neice 1222 Trenton Pl. S.E. Wash. D.C. 20032 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dale 20c. Location - City or Town, State 1 2 Burial 2 Cremetion 3 Removel from Stete Md. Vet. Cem. 6/6/2000 Cheltenham, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Funeral Service Licensee 22. Name end Address of Fecility Hodges and Edwards 3910 Silver Hill RD.Suitland, Md. alver 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and, or heart feiture. List only one cause on each line. Approximate Intervet Between Onset and Death **Physician** Immediate Cause (Fine) disease or condition resulting in death) /Medical Examiner Due to (or as a conseque Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed effor death.

Director: After this certificate has been signed by the attending physician and After this certificate has been signed by the attending physician and funeral director, page 2 should be deteched for use as the buriel-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to 24a. Wes en eutopsy completion of cause of death? 2 No 1 Yes 1 TYes 2 □ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification: To 1 Yes 2 ER/Outpatient 3 DOA 27. Manper of Death 1 Netural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Yes 2 No 2 Accident 4 To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and menner es stated (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and menner steted. 29b. Signature and title of certifier 29c License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Prht) Va William L. Steinberg M.D. 7503 Surratts Road, Clinton Md. 20735 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** 13:41 Randolph C. Thorne 7-2000 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** WASHINGTON MINICE GEORGES HING TON FORT WAS 8. Dete of Birth Nov. 18, 1940 If Under 24 Hrs. 5. Sociel Security Number 9. Birthplece (State or Foreign Washington, D.C 7. Age (In yrs. lesf birthdey) **Funeral** Months 578-54-6264 59 Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Haelth and Mental Hygiene. Important: If item 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinas must be notified at 10d. inside City Limits Prince George's Fort Washington Maryland 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12021 Livingston Road USA 20744 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American indien, Bleck, White, etc. IXOYes 2□No1960— If Yes, Give Yeer or Detes: 1964 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ◯ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White 1964 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Quality Assurance Federal Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumame) Be Clarence Thorne Ruby Dishner 19e. Informent's Neme/Reletionship (Type, Pnnt) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Donna J. Deters/POA 926 Palmer Rd. Apt. 11 Fort Washington, Md. 20744 20b. Piece of Disposition (Name of cometery, cramatory or other piece)
Mary Land Veterans Cem. 6/5/2000 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removei from Stete Cheltenham. Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatury Funeral Service Licensee George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 also 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** immediete Ceuse (Finei diseese or condition resulting in deeth) /Medical CANDIOUASCULA Examiner Due to (or as a consequence of) 324321G Physician/Medical Examiner the attending physician end ned for use as the bunel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Records, P.O. Box 68760 The law requires that the death certificate be Due to (or es a consequence of): USB 85 ò Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en autopsy certificate has 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitai: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2X ER/Outpetient 3□ DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Deeth Medical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel injury 1 Yes 2 No 2 Accident 6 Couid not be determined 3 Suicide 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Streef and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as stated.

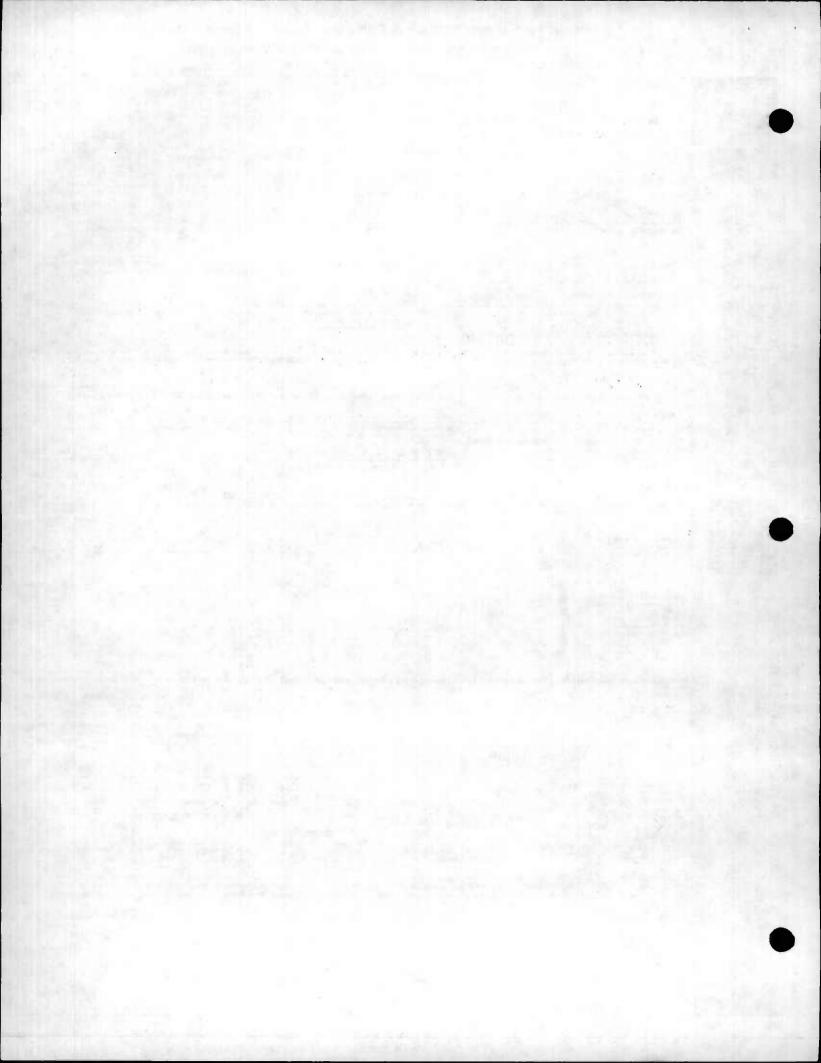
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) end menner steted. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Typa, Print) CONTER WALDORF, Md. 20602 15875KU 14.0 12070 OUN 32. Registrer's Signeture MAY 3 0 2000 31. Dete filed (Month.

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day 2000 Month Day **Physician** V. Essie Taylor 11:00 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10903 Amherst Avenue #221 Wheaton Montgomery 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) **Funeral** Days Months Hours 10M 20F 214-30-8643 89 Yrs. 12/14/1910 Director Virginia Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be nothing at 1 XYas 2 No Director Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 'natural', or itema 23a 21804 USA 411 Coles Circle Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien, 11. Marital Status Black, Whita, atc. filed within 72 hours effer. Hygiene. other than "natural", or its 1 Nevar Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 ₩ Widowed 4 Divorced white Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Domestic other 17. Fathar's Nama (First, Middla, Last) permit. Pages 1 end 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked oth any lollury or other traumatic avant potes. 18. Mother's Nema (First, Middle, Maiden Sumame) Be Sewell Franklin Williams Delia Bonneville 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 10905 Amherst Ave., Apt. 221, Silver Spring, MD 20902 Jean Taylor (daughter) 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Slata 1 Burial 2 Cremetion 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 6/5/00 First Baptist Cemetery Pocomoke City, MD 21. Signatura of Funaçal Sarvice Licensee 22, Name and Address of Facility
Holloway Melson Funeral Home, P.A. Ran 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximata Intarval Between Onset and Deeth **Physician** Immediata Cause (Final disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence of): Physician/Medical Examiner physician end s the burial-trensit that the death certificate be executed Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaase or Injury Due to (or as a consequence of): P.O. Box 68760 that initiated events rasulting in death) Last Dua to (or as a consequence of) **USB 88** Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown signed t Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an eutopsy performed? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vitai or Attanding Physician: 25. Wes casa raterred to medical 26. Place of Deeth (Check only one) examinar? Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) Certification: To 1 ☐ Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Deta of Injury (Month, Day Year) 27. Manger of Death 28b. Tima of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident invastigation Director: / 6 Could not be datarmined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, street, fectory, office building, atc. (Specify) 24 hours after de Funeral Direct Netely filled in by 4 Homicida Hospital edical 29a. Certifier 💢 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated. To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and titla of cumila 29c. License number 29d. Data signed (Month, Day, Year) arin 30. Nama and address of person who complated causa of death (frem 23a) (Type, Print) Laurel Chem Lnc 32. Registrar's Signatura 31. Dala filad (Month, Day, Year) State Registrar



		State of Marylan		artment of I tificate of			giene ()	0 192	50
Physician /Medical	Decedent's Neme (First, Middla, Las     OLA CAGE WR	0 IGHT				2. Dete of De Month MAY 29	Dey	3. Time of 2:32	
Examiner	4e Fscility Name (If not institution, give Livingston Heal		-			n, or Location of Death HINGTON	4c. County	of Death E GEORGE S	
Funeral Director	5. Social Security Number 6. Security Number 10	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir	v Year)	9. Birthplace (State of Country) Leesdale, M	r Foreign
8	Usual Rasidance of Decedent 10a. Stete 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside Ci	
ments of thous site oeen with the maryans than 'natural', or items 23s or 28s-1 show the Medical Estam her must be included at ompleted by Funeral Director	Maryland Prince Ge	eorge's F	OREST	HEIGHTS				1 <b>∑</b> Yes	2 N
I Dir	10e. Street end Number 5715 OTTAWA ST	P		10f. Zip Code	745		10g. Citizen of V		
r hems 23 niver must Funeral	11. Meritel Stetus	S. 13. V					USA  14. Race - American Indien, Black, Whita, etc.		
er, or h	1 Never Married 2 Merried 3 N Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Give Yeer or Dates:		If Yes, specify Cuban, Mexican, Puarto  1 ☐ Yas 2 X No Specify:			Specity: BLACK		
ygiene. Net than *nature It, the Medical Completed	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondery (0-12) 9th  16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)  COOK					working PRIVATE			
arked other atic avant, tr	17. Father's Name (First, Middle, Last) BUNION CAGE, SR.			18. Mother's Name (First, Mic CALLIE JA					
ris me trauma	19e. tnforment's Neme/Ralationship (7) MAGGIE ROLLS/ DA	ype, Print) AUGHTER		og Address (Stree		or Rural Route Numb	-		
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lant: If jury or	1 Burial 2 Cremetion 3 24 4 Donetion 5 Other (Specify			CEMETERY		6-3-00	LEESDAI		
any in	21. Signeture of Funerel Service Licens	& Braylor	7 43	Neme and Addr	AND RD.	MARSHALL'S SUITLA		HOME OF M	ID
e attending physician and softensit for use as the bunel-trensit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that intitleted events resulting in death) Last	b. Colore to (o	As a consequence as a consequence	uence of):	dio	enr		17	~
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by the tached	Pert II. Other significant conditions co	ntributing to death but not rasulting In the underlying cause given in Pert i.					23b. Did tobacco use contribute to the cause of death  1 Yes 2 No 3 Probably 4 Unknown		
page 2 should be deficient to be completed by P							24a. Was an eutopsy performed? 24b. Were autops available pric completion of death?		lo
page 2						10	res 2K) No	1 🗆 Yes 2 🗆	No
s certificate director, pag To Be Co	25. Was case raferred to medical examiner?	Hospitel:				Death (Check only o	_		
	27. Manper of Death	28a. Date of Injury 28b. Time of 28c. Injury at					lome 5 ☐ Rasidence 6 ☐ Other (Specify)  28d. Describe how injury occurred		
the Funeral Director: After the mpletely filled in by the funeral Medical Certification:	1 Neturet 5 Panding 2 Accident Invastigation 3 Suicide 6 Could not be 4 Homicida	(Month, Day Year)  28e. Pleca of Injury - At he building, etc. (Specifi		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
he Funeral D pletely filled edical Ce		sicien: To the best of my kno- ner: On the bests of examine							6)
Med	29b. Signature and title-of-certifier	end menner steted.	-	29c. Licen	se number		29d. Dete signe	d (Month, Day, Year)	
(1)	1/1/2	MA	Elevy	5 3	-245	35	05	30.00	
6)	30. Name and address of person who back DR. LAXMI N. BE	repleted cause of death (flore RWA 7700 OLD		4	SUITE C	101 CLIN	TON, MD	20735	
State Registrar	31. Dete filed (Month, Day, Year)	32. Registrer's Signa	tura	4					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First Middle Last) 2. Dete of Death 3. Time of Death Physician Yee 241 IDA MARLENE WASHINGTON 2000 /Medical 4c. County of Death 4a Facility Neme (tf not institution, giva street and number) 4b. City. Town, or Location of Death Examiner STREE PRINCE GERGES PARKON WASHINGTON 2010 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** Months Days 1□ M 2□xF 58 Yrs. ASHEVILLE. 246-60-3578 Director 1941 Usual Residence of Decedent with the Meryland 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow rthan "natural", or itema 23a or 28a-f ahov the Medical Examiner must be notified at 1 X Yes 2 No Director Maryland Prince George's FORT WASHINGTON 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 12229 PARKTON STREET 20744 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - American Indian 11 Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yas 2 No Specify: BLACK Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elemantary/Secondary (0-12) 12th College (1-4or 5+) CLAIMS ADJUSTER FEDERAL GOVT. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be CLINTON HANKERSON, SR. GERTRUDE PLATTS 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) JOHN WASHINGTON/ HUSBAND 12229 PARKTON ST. FT. WASHINGTON, MD 20744 20b. Plece of Disposition (Nama of cematary, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State WASHINGTON NATIONAL CEM. 6-3-00 4 ☐ Donation 5 ☐ Other (Specify) SUITLAND , MD 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Signature of Funeral Service Licenses 4308 SUITLAND RD. SUITLAND, MD 20746 23a. Pert1. Enter the disease, or complications that caused tife deeth. By not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final diseesa or condition resulting in death) /Medical 8= Examiner CARDIOVASCULAR DISEASE Physician/Medical Examiner skian end buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. attending physician for use as the burie that initiated events resulting in death) Last Due to (or es a consequence of): P.O. I Pert II. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Onknown 1 Yss 2 No signed b Division of Vital Records. ð Completed 24b. Were autopsy findings avellable prior to page 2 should 24a. Wes an autopsy performed? completion of cause of death? 2 0 No 1 Yes 1 ☐ Yes 2 ☐ No certificate or Attanding Physician: director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only ona) examinar?
1 Yes 2 No Other: 4 Nursing Home 5 Appliedence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) Manner of Death 28d Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 BNaturel 5 Pending after death. 1 Yes 2 No investigation 2 Accident ampletely filled in by the 3 Duicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the causa(s) and manner as stated.

1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Certifier ination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) To the F Tothe 29b. Signiture 29c. License number 29d. Dete signed (Month, Dey, Year) m 23a) (Type, Print)

Registrar DHMH 16 Rsv 6/95

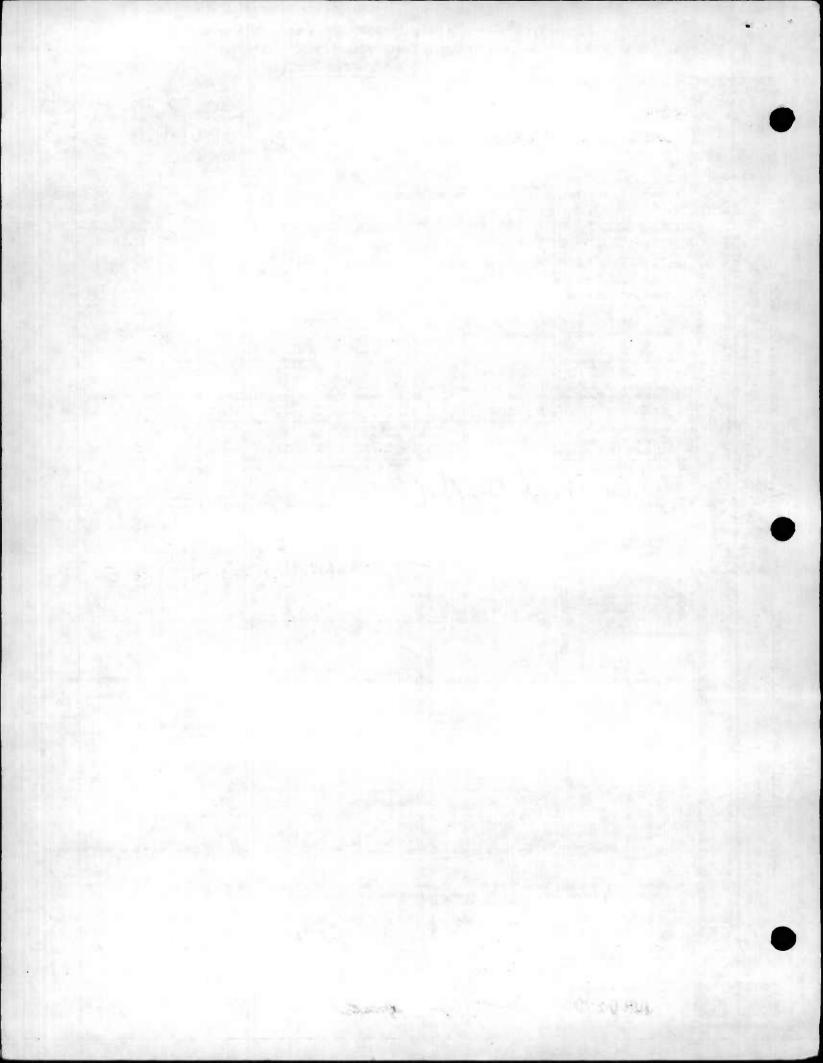
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32. Registrar's Signature

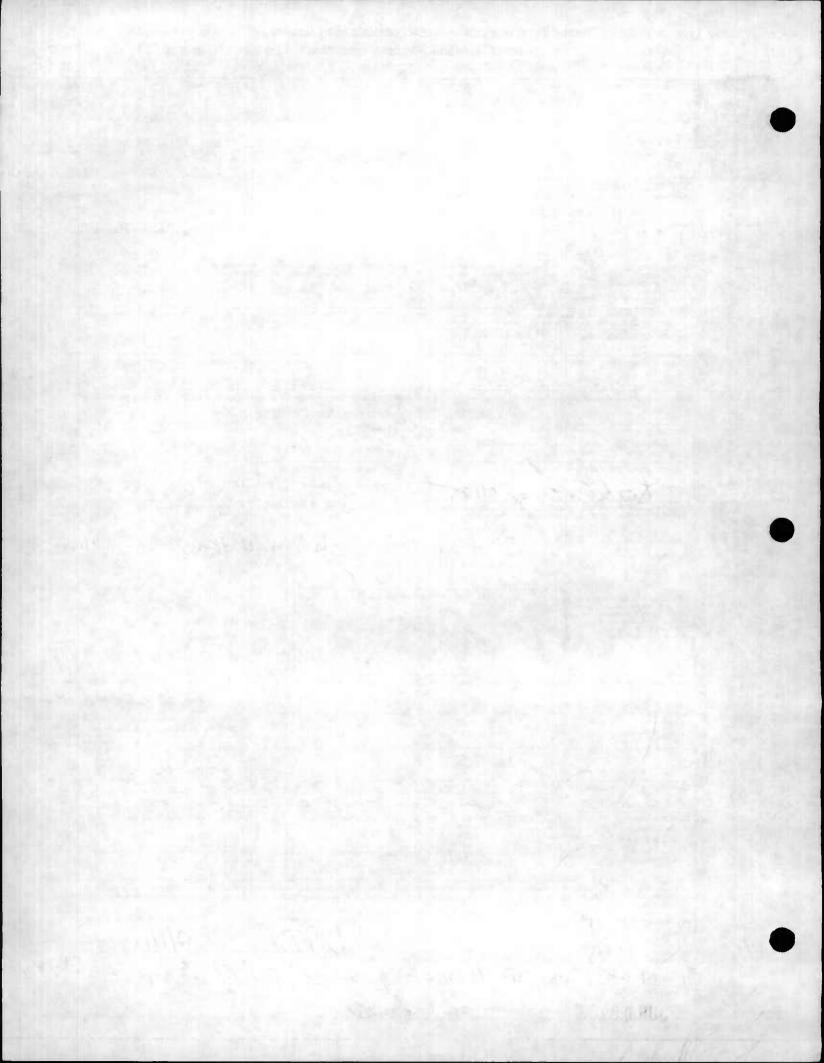
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JUN 0 2 2000



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1. Decedent's Name (First, Middle,	Last)	Ce			2. Date of De	Reg. No. ath	3.	Tima of Death
ian SAMUEL JULIUS		2			Month MAY	30,2000	Yeer 1	2:00am
ner 4a Facility Name (If not institution,	give street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
7916 Allendale	Dr.			Landover		Prince	George	e's
5. Social Security Number 578-64-0917	Sex 7. Age (I	n yrs. last birthday) 52 yrs.	Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da			(Stete or Foreign
	QU 10 201	32 Yrs.			Feb. 1			ngton, D.
Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. lr	nside City Limits
Maryland Prince	George's	Landove	er				1	Yes 2□No
Maryland Prince 10a. Street end Number			10f. Zip Code			10g. Citizen of W	Vhat Country?	
	r.		20785			United	States	
7916 Allendale D  11. Marital Stetus  1. Never Married 2□ Married	12. Was Decedent Eve Armed Forces?	er in U,S. 13.	Was Decedent of	Hispanic Origin? (Sp pan, Mexican, Puerto	ecity Yea or No	- 14. Race	a - American In- k, White, etc.	dian,
			1 ☐ Yes 2√ No		riicari, etc.,		Black	
3 Widowed 4 Divorced  15. Decedent's  (Specify only highest to be considered to be consider		16a. Dece	edent's Usuai Occu	pation during most of work	dina	16b. Kind of Bu	siness/Industry	
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17. Father's Name (First, Middle, La				18. Mother's Nam		Maiden Sumemi	θ)	
Samuel J. Willi		100		Romaine				
19a. Informent's Name/Relationship				t end Number or Rui				
Wilhelmena C. W		20b. Ptace of Dispo		ve. Distr	Date Date	20c. Location		
1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removat from State	cemetery, cre	metory or other pla v Memori	7 70 1	/3/00	Brentwoo		Jiaio
21. Signature of Funeral Service Lice		22	2. Name and Addr	ess of Facility				
1 Xita	from MIN	-	Alexander	r S. Pope Lboro Pike	Funeral	Homes	Md. 20	747
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shock, or neert feiture. List on	ity one cause on each line.		to the mode of dy	ing, such as cardiac	or respiretory at	rrest,	, app.	
			no mo modo or dy	ing, such as cardiac	or respiretory at	rrest,	Inter	roximate rvat Between et and Death
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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						C	ertifica	te of	Death		Reg. No.	UU	19253
	2. [1]	1. Decedent's Nama (Firs	t, Middle, La	st)						2. Date of Month		Vans	3. Time of Death
	Physician /Medical	Louise E	E. Wi	11iams	5					May	30, Day	2000 Year	5:30 Am
	Examiner	4a Facility Name (If not in	nstitution, giv	e street and nu	mber)				4b. City, Town,	or Location of D		County of Death	
		Southern	Marv	land H	Hospit	a1			Clint	on	Pr	ince G	eorges
П	Funeral	5. Social Security Number	6. S	ex	7. Age (In yrs		y) If Und	or 1 Year	If Under 24 F	irs. 8. Date of (Month,	Birth Day Yearl	9. Birth	place (State or Foreign
	Director	577-26-51 Usual Residence of Dece	78	□M 22X)F	7	7 Yrs.	Months	Days	Tiours III	Marc	h 13,		Virginia
	how	10a. State 10b.	County		10c. C	ity, Town or	Location						10d. Inside City Limits
	cto	MD. P:	rince	Georg	ges	Uppe	er Ma	rlb	oro			1 4	1⊠ Yas 2□ No
	ath with the Marylan 23a or 28e4 show unit be notified at ral Director	10e. Street and Number 9710 Green	n App	le Tui	cn			ip Code	2			en of What Cou	
	r Heme 23 Transment	11. Marital Status		12. Was Dec	edent Evar in	U,S. 13	. Was Dec	edent of	Hispanic Origin? an, Mexican, Pu	(Specify Yes or	No- 1-	4. Race - Ameri	
21215-0020	0 9	1 Never Married 2		Armed For 1 Yes If Yes, Gir Year or D	2 (2)(No				Specify:	ierto Rican, etc.)		Black, White Specify: Bla	
0	"natural".	15. D	ecedent's Ed	lucation		16a. Dec	edent's Us	ual Occu	pation		16b. Kin	d of Business/Ir	
215	ed within 72 ho ygiene. or then "naturi ft, fre tredient Completed	(Specify only Elementary/Secondary		de completed)	1 Apr Eu	(Gin	Pe kind of w	ork done use retire	during most of v	working			
21	d within piene. r than re the	12	(0-12)	College (	1-401 5+)	Но	usek	eep	ing		Pr	ivate	
P	ETES .	17. Father's Name (First,	Middle, Last)						18. Mother's N	Name (First, Mid	dle, Maiden S	Surname)	
iai	and Mentel marked of marked ov	William Mo	oten						Mari	e Bosw	e11		
Maryland	# DE E	19a. Informant's Name/Re	elationship (	Type, Print)		19b. Ma	iling Addre	ss (Stree	and Number or Apple	Rural Routa Nu	mber, City or	Town, Stata, Zi	p Code)
Σ	DELE	Annette M.	. Str	oud/ni	ece	971 Upp	er M	een	boro,	Maryla	nd 2	0772	
re,	or other	20a. Method of Disposition			20b.	Place of Dis				Dete		ation - City or T	own, Stata
Baltimore,	Pages nent of h int: If he	1 X Burial 2 ☐ Crer 4 ☐ Donation 5 ☐ C							em. PK	6/3/2	000	Laurel	, MD.
=	permit. Pag Department Important: I eny Injury o	21. Signature of Funeral S		· · · · · · · · · · · · · · · · · · ·	rib			-	ass of Facility	Hodge		dwards	
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	Physician /Medical	Immediate Course (Final		/	2 /	6	)		٨		1		Crisel and Death
ľ	Examiner	Immediate Cause (Final disease or condition resulting in death)		a	Cand	M-	Us-	m	non	for	line	, 1	
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Т	B 를 들			b	reu.	ton	his	•		V			
	cets be executed physician and a the burlal-transit edical Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying	is,		Oue to	or as a cons	equence of		A				
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Box	e attendi			0.								!	
o.	e de la la la la la la la la la la la la la	Part II. Other significant of	conditions o	ontributing to d	eath but not ra	sulting in the	underlying	cause gi	ven in Part I.	23b. E	ld tobacco u	se contribute	to the cause of death?
<u>~</u>	ules that the death or signed by the attend of be detached for us d by Physician/									1	□ Yes 2)	No 3□ Pro	obably 4 Unknown
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of Vital Records,	been shou										as an autops erformed?	a	Vere autopsy findings vailable prior to ompletion of cause f death?
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ā	yeiclen: Tha i s cartificate hu director, page To Be Corm	25. Was case referred to	medical						OC Dises of F		-	1	143 20140
5	Physician: rithis cartific aridirector, TO Be (	axaminer?	Troul Car	Hospital:		☐ ER/Outpati	ent 3 D	Ot Ot	hor	Death (Check or		Don. 10	9.1
		27. Manner of Death		28a. Data		28b. Time				g Home 5 ☐ R	be how injury		ny)
0	Afte fune	1 Naturat 5 🗆	Pending investigation	(Mon	th, Day Year)	Injury		28c. tnju Wo	rk? ]Yes 2 □ No				
S	Attending or deeth. ector: After by the fune iffication	2 ☐ Accident 3 ☐ Suicide 6 ☐	Could not be	-	of tnjury - At I	nome form			7.00 20.00	28f Locatio	n /Street and	Number or Ru	ral Route Number,
Division	bal or Attending P is after deeth. el Director: After t ed in by the funer: Certification:	4 Homicide	determined		ing, atc. (Spec		stroot, tack	iy, onice		City or	Town, Stata)		a. Frosto Francos,
	To the Hospital or Attanding Ph within 24 hours after desth. To the Funeral Director: After th completely filled in by the funeral Medical Certification; 1	29a. Cartifier 1□ C	artifulne m	valcian. T. d.	boot of our t-	audadas d	th east-	d no str - c'	ma data cod 1	no and disk	ha acus=(-)	and manage	eteted
	To the Hospital within 24 hours To the Funeral completaly filled Medical C		ledical Exam	iner: On the b	asis of axamin ner stated.	ation and/or	investigatio	n, in my	ma, data and pla opinion, death or	ccurred at the tin	ne, data and	place, and dua	to tha cause(s)
	within To the comple	29b. Signastire and still of	300	and men	statou.		2	9c. Lican	se number		29d. Date	signed (Month	Day, Yearl
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	13)	30. Name and address of	person who	completed caus	se of death (Ite	m 23a) (Type	e, Print)	40	71	11 11		sh d 1	1 - 2 -
		03.0-[[]	[Y]	) /(	303	Sul	ru	12	KO	LINI	on, I	1100	×0/35
	State Registrar	31. Date filed (Month, Day	2000	Se	legistrar's Sign	ature	la	11					

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death May 24, 2000 Physician Elsie Mae Wiggs 1:39pm /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Regency Nursing Home Forestville Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthpiece (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Deys Months 1 ☐ M 2 🖾 F 64 Director 245-56-1523 Feb. 2, 1936 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f sho the Many Maryland Prince George's 1 Yes 2 No Capitol Heights Funeral Director I Hygiene other hasture, or items 23s or 28s-f other than hadlest Examiner must be notified vent, the Medical Examiner 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5003 North Inglewood Dr. United States Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2√ No Specify: Specify: Black þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Secretary Public Schools 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file. Department of Health and Mantal Hy important: if then 27 is marked other any fejury or other traumatic event abbs. Be Forest Wilder Mitchell Lila 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 5003 Englewood Dr. Capitol Heights, Md. 20743 Reginald Wiggs/ Son 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 5/31/00 Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 21. Signature of Funeral Service Licens 22. Name end Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, 20747 23a. Part1. Enter the dispase, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical Metastatic Lung Cancer Examiner Physician/Medical Examiner The law requires that the death certificate be executed signed by the attending physician and d be detsched for use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): thet initiated events resulting in deeth) Last Due to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown by 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has been si funeral director, page 2 should it Completed 24e. Wes an autopsy performed? 1 Yes 2 No 1 □ Yas 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 8 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Universing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier Slow C. Ly 039550 5-25-00

Registrar **DHMH 16 Rev 6/95** 

State

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

George C. Hajjar Jr. m.O. 4850 For bes Blod. Lunham. md. 20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

612000

31. Date filed (Month,

JUN

de l'arte en la serie de la company

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedenf's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2000 MIRIAM REBECCA WILKES MA /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street and number) 4c. County of Death Examiner CAMP SPRINGS 1100 PINCE GEORGES BUCHANAN ROAD # Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) SAVANNAH, GA 5. Social Security Number **Funeral** Days 256-62-2489 18,1940 Director Usual Residence of Decedent 5 1/4 Plakew 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at MYes 2□ No Director MD PRINCE GEORGES CAMP SPRINGS 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7109 BUCHANAN RD 238 20748 UNITED STATES Funeral Rema 2 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22000 # Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene, in 72 hours after a Important; If 1 fem 27 is marked other than "natural", or ther any injury or other traumatic event, the Marian and Robe. 1 Never Merried MA Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: BLACK Specify: à Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) HOTEL WORKER PRIVATE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GENE WASHINGTON REBECCA HOLLIS 10 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS WILKES / HUSBAND 7109 BUCCHANAN RD CAMP SPRINGS, MD 20748 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from Stete RESURRECTON CEMETERY 5-26-00 4 ☐ Donetion 5 ☐ Other (Specify) CLINTON, MD 21. Signature of Furnish Service License 22. Name and Address of Fecility
ALEXANDER S. POPE FUNERAL HOME apre ummens 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part1. Enter the diagram, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical ARTERIOS CUEROTIC CARDIOVASCULAR DISERRE Examiner Due to (or as a consequence of) Physician/Medical Examiner that the death certificate be executed ician and burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting In death) Last Due to (or as a consequence of): physician is the burial Box 68760. Due to (or as a consequence of) 80 P.O. Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ed by th 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Vinknown Records, þ been signe should be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at 28d. Describe how injury occurred Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of fnjury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After 1 Neturel 5 Pending death. 1 Tyes 2 No investigetion 2 Accident after death Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide 24 hours a 29a. Certifler Medical 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stafed. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar MARIO

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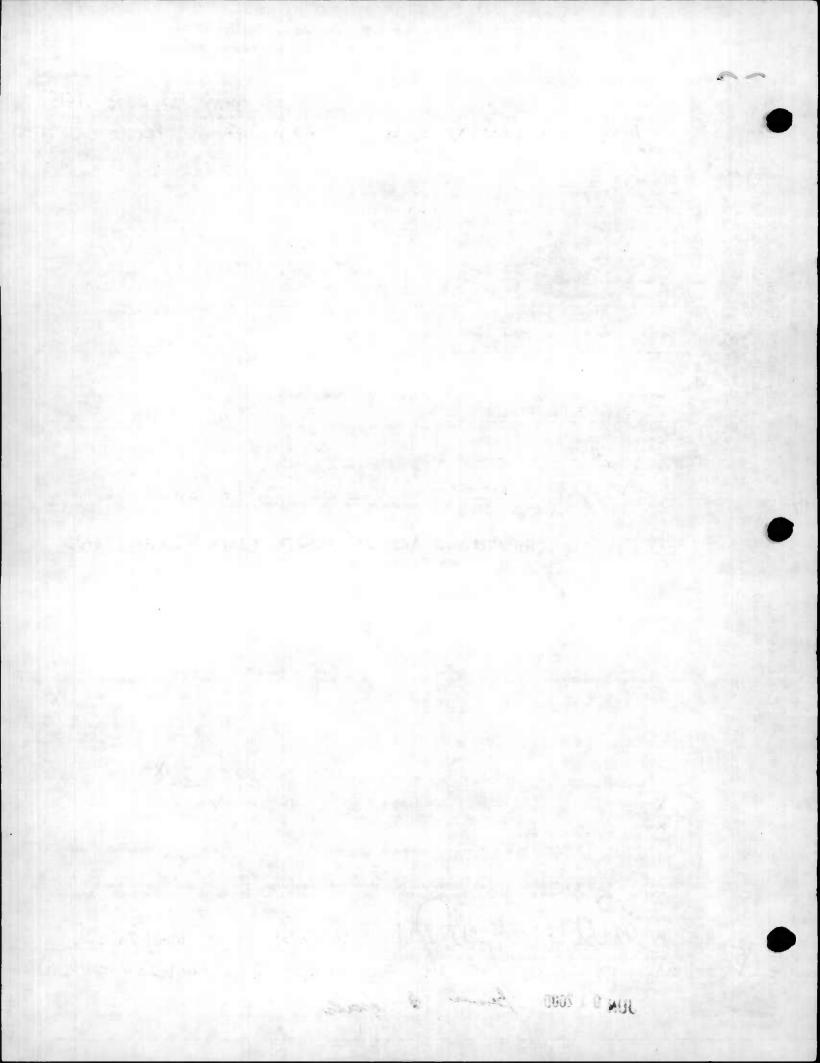
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e of death (Ite

Registrar's Signature



### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene \(\) 1, Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Physician ISAIAH WILLIAMS May 24 2000 2:00 PM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death **Examiner** Glays Spellman Nursing Home Cheverly Prince George's If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1XM 2□F 578-16-2989 Yrs 86 Director May 07 1914 South Carolina Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show way fourty or other traumatic event, the Medical Evantine must be notified at once. 10a Stete 10b. County 10c. City, Town or Location 10d. Inaide City Limits 1 X Yes 2 □ No Maryland Prince George's Directo Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Graiden Street 20774 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yas 2 ☐ No If Yes, Give Yaar or Datas: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. 11. Merital Stetus 1 ☐ Nevar Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: ۵ 3 Widowed 4 X Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Government 10th 18 Mother's Name (First Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Eugene Williams Victoria Neilon 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Michael William, Sr./Son 103 Graiden Street, Upper Marlboro, Maryland 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 X Buriel 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 2000 Landover, Maryland J.B. JENKINS FUNERAL HOME 21. Signeture of Funeral Service Licensee 7474 Landover Road, Landover, Maryland 20785 Percen 23a. Pert1. Enter the dise e, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heer tall in List only one causa on each line. Approximata Intarval Batween Onset end Death **Physician** Immediate Ceuse (Final disease or condition rasulting in death) /Medical Sepsis **Examiner** Due to (or es e consequence of): Examiner Failerre Renal 4 cute requires that the death certificate be executed Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last use es the buriel-tran Due to (or as a consequence of): ere Gangrene
Due to (or as e consequence of): P.O. Box 68760, the attending physician evere Physician/Medical Vascella Direay ventilator Respiratory Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 6 1 Yss 2 No 3 Probably 4 Unknown Diabeter Division of Vital Records, p 24b. Were autopsy findings aveilable prior to complation of causa of death? 24a. Was en eutopsy performed? Completed Sacral decerbitus u/cers Alzheimers 1 Yes 20100 1 ☐ Yas 2□ No.

page 2 s certificate has

filled in by

Be

Certification: To

edicai

25. Was case ratarred to medical examiner?

29b. Signature end title of cartifier

5 Panding investigation

6 Could not be determined

1 Yes 2 No

27. Mannar of Death

1 PNatural

3 ☐ Suicide

29a. Cartifiar

4 Homicide

(Check only one)

2 Accident

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certific To the Hosp within 24 hou To the Fune completely fi

State Registrar

MD Nancy Kalpana Gimoty

28a. Data of Injury (Month, Day Yaar)

1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date end placa, end due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, end dua to the causa(s) and manner stated. 29c. License number

20052848

26. Placa of Daath (Check only one)

Othar: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

29d. Date signed (Month, Day, Year)

30. Name end eddrass of person who complated cause of death (Itam 23a) (Type, Print) NANCY K

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Avenue Landoner

Hills

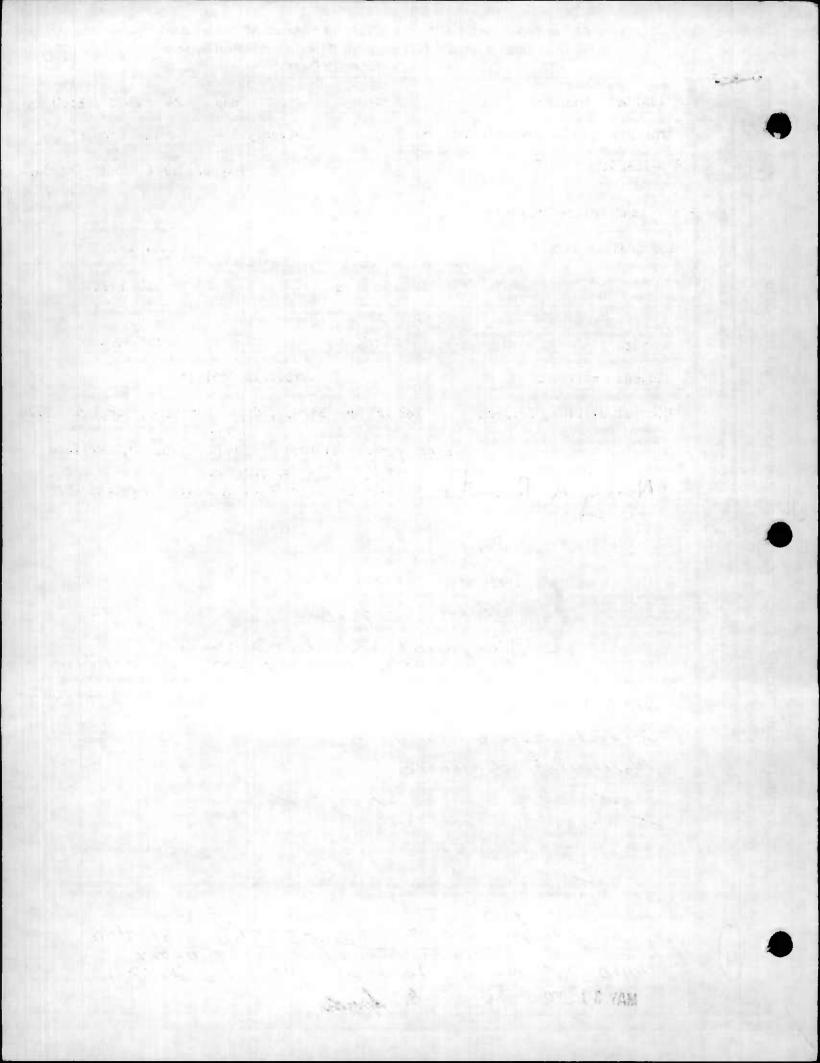
28c. Injury at Work?

37 Registrar's Signatura 31. Date tiled (Month, Day Year) MAY 3 1 2000

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28b. Time of Injury

28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify)

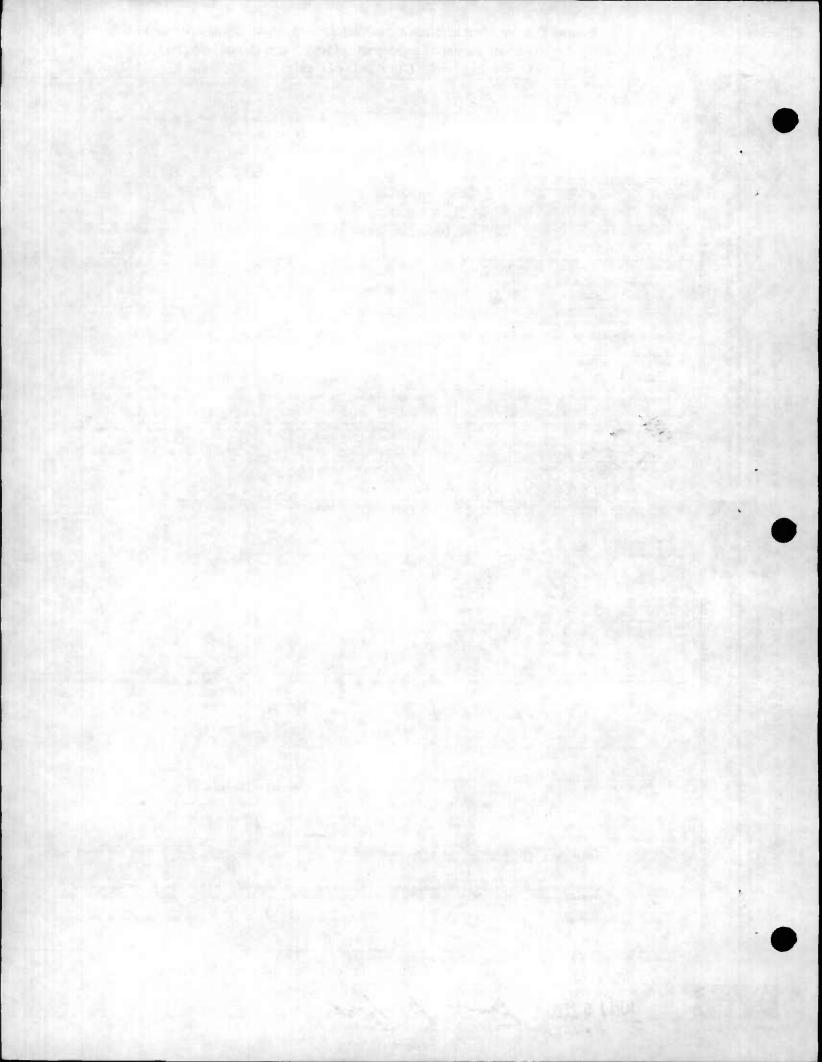


B.K.S ROLLAN	PnB <sup>A</sup>	Y YOUNG #2	Please	Type or Prin State of Ma 27 PER ME	ndand	I / Dona		Health and	Mental Hy	_	00 1925 <b>7</b>
Phy	sician	1. Decedent's Na	me (First, Middle, Las ID RAY YO	t)					2. Date of De Month JUNE	Dey 5, 2000	Year 1334 PM
	edical miner		(If not institution, give					4b. City, Town, or HAGERS	Location of Deat	h 4c. County	
Fune Direc		5. Social Security 433-96	Number 6. Se 5 - 8902			st birthday) 45 Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs	8. Date of Bir	y, Year)	Birthplace (State or Foreign Country)     Louisiana
ryland		Usuai Residence	10b. County			Town or Lo			104		10d. Inside City Limits
death with the Maryland	Director	MD 10e. Street and N		on County	Hag	erstov	VN 10f. Zip Code			10g. Citizen of V	1 ☐ Yes 2 🛣 No What Country?
th with	a Di	11207	Marbern Ro	ad				21740		U	J.S.A.
, à 2	by Funeral		rried 2 Married 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates:			Vas Decedent of f Yes, specify Cut □ Yes 2⊠ No	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Specify	a - American Indien, ck, White, etc. w: White
nin 72 hours a	Completed	(Spi	15. Decedent's Ed ecify only highest grad	ucation de completed)		16a. Deced	lent's Usuel Occu kind of work done OO NOT use retire	pation during most of wo	orking	16b. Kind of Bu	usiness/Industry Services
206	dwo	Elementary/Sec		College (1-4or 5	+)		nt Execu			First I	Data Merchant
C, Mai yiana ZIZI  1 and 2 should be filed within Health and Mental Hygiene. Find 2 is marked other than "	Bec		e (First, Middle, Last) Ray Young	g. Sr.					me (First, Middle Jean Ba		10)
should nd Mer merke	70		Name/Relationship (7			19b. Mailin	ng Address (Stree	t and Number or R			State, Zip Code)
and 2 salth a		Rolland	Ray Young	g, Sr./Fat	her	421	Starview	Drive,	Georgeto	wn, Texa	as 78628
permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: It fam 27 is marked other the control in the con			isposition  Commation 3  Other (Specify		COL	metery, cren	sition (Name of natory or other pla eek Ceme		June 9		City or Town, State
Demili Depending	Buch	> Ke	The disease, or complete list only of	Zinne	the death.	13	331 East		, N., Hage	erstown,	Maryland 21742 Approximate Interval Between Onset and Death
Physici /Media Examin	cal	Immediate Cause disease or condit resulting in death	ion	PULM	ONARY	TROM	BOEMBOLI	SM			Oriset and Death
	e e	resulting in death	,		Due to (or	as a conseq	uence of):				
be executed sician and burief-rancing	Examiner	Sequentially list of any, leading to cause. Enter Und	conditions, immediate derlying	b	Due to (or	as a conseq	uence of):				
es that the death certificate be igned by the attending physicia	Physician/Medical	Cause (Disease of that initiated even resulting in death	nts	d	Due to (or a	as e conseq	uenca of):				
death death	siciar	Part II. Other eign	nificant conditions co	entributing to death bu	ut not result	ting in the ur	nderlying cause g	iven in Part I.	23b. Dld	tobacco uee co	ntribute to the cause of death?
s that the	by Phy	DEEP	VEIN THRO	OMBOSES					10	Yea 2 No	3 □ Probably 4 Unknown
require sebould	eted									an autopsy ormed?	24b. Were autopay findings evailable prior to completion of cause of death?
The lew	Com								1)0	Yes 2 No	1 Yes 2□ No
Physician: The this certificate all director page	Be	25. Was case reference?	+	Hospital:			_ 0	lhor:	eath (Check only		
To the Hospital or Attanding Physician: within 24 hours after death. To the Fureral Director: After this certific	ation: To	102 Yes 2 ☐ 27. Manner of Der 1 ☐Natural 2 ☐ Accident	JNO	28a. Date of Injur (Month, Day		Proutpation 28b. Time of Injury	28c. Inju	4 Li Nursing	Home 5 Res	how injury occur	ALL LANGERS
To the Hospital or Attending F within 24 hours after death. To the Furseral Director: After	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Placa of Injubuilding, etc	ury - Al hon . (Specify)	ne, ferm, str	eet, factory, office			(Street and Numb wn, State)	ber or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Director of the Funera	edicai C	29a. Certifier (Check only one)		rsician: To the best of liner: On the basis of and manner sta	examination						anner as stated. and due to the cause(s)
To the To the	Me	29b. Signeture en	nd little of certifier	1	/		29c. Licen	se number	49.8	29d. Date signe	ed (Month, Day, Year)
			YN	NI. 1A			0.	C.M.E		JUNE	6, 2000
		30. Name and add	dress of person who d	completed cause of de				, Baltim	ore, Mar	yland 2	1201
	Chata	31. Date filed (Mo	onth. Day. Year)	32. Registra	r's Signati	ITA					

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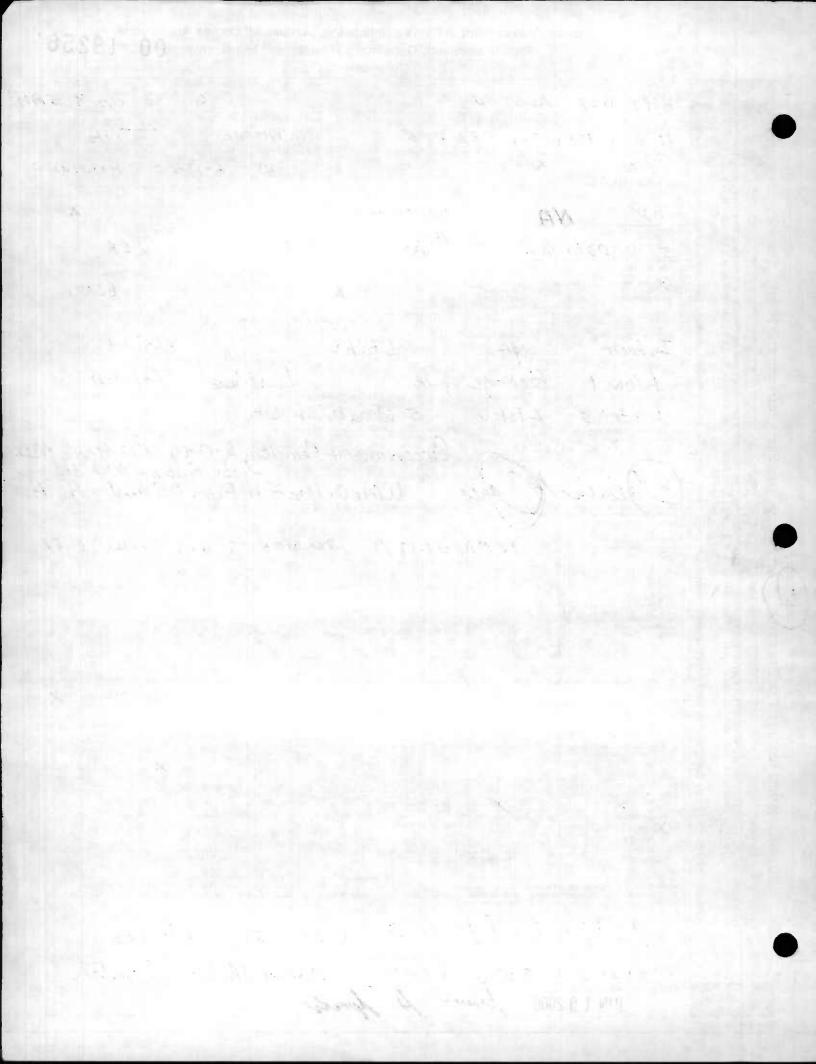
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1925

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Tima of Deeth Day Month **Physician** 6 8:25 AM ALSTON BABY BOY 00 /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE MERCY MEDICAL CENTER If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthpiaca (State or Foreign Country) 5. Sociei Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 1.8 M 2□ F N/A MARYLAND Director Usual Rasidance of Decedant t0a Stala 10c. City, Town or Location 10d. Insida City Limits T is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Exemplest must be nothed at 1 Yas 2 □ No HD BALTIMORE Director 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? Apt. 21216 USH 5 WOODBRIAR CT. Funeral 12. Was Decedant Evar in U,S.
Armed Forcas?
1 ☐ Yas 2 No
If Yas, Giva
Yaar or Datas: 14. Race - Amaricen Indian, Bieck, Whita, atc. Was Decedant of Hispanic Origin? (Spacify Yas or No-if Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 11. Marital Status Fages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygians.

The marked other than "natural", or its 1 Navar Marriad 2 Married 1 ☐ Yas 2 No Specify: Baltimore, Maryland 21215-0020 BLACK Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Collega (1-4or 5+) Infant 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be 2 Grearage NONCI 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stafe, Zip Code) Woodbrian 5 Department of Health Important: If Item 27 - a trice HISTON 20b. Place of Disposition (Neme of metery, crematory or other place, 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Buriai 2 Cramation 3 Ramoval from Stata
4 Donation 5 Othar (Specify) injury or 4 Donation Cemelen of Funarai Sarvice Licens 22. Nama and Addrass of Facility 1101E. North march Approximata Intarvai Batween Onsat and Daath 23a. Part1. Entar tha disaasa, or co shock, or haart failura. List onl tha death. Do not antar the mode of dying, such es cardiec or respiretory arrast, Physician /Medical Immediata Causa (Finai 20 WEEKS GESTATION disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of): Examiner Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consaguance of): Physician/Medical the Dua to (or as a consequence of) Division of Vital Records, P.O. Box 687 88 950 signed by the al Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 □ Probably 4 ÛUnknown 1 Yss 2 No py 24b. Wara autopsy findings available prior to complation of ceusa of death? Completed 24a. Was en autopsy 1 Yas 2 No 1 TYas 2 No. or Attanding Physician: funeral director, 25. Was cesa rafarrad to medicai axaminar? 26. Placa of Daath (Check only ona) Hospitai: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yas 2 No Certification: To After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accidant ofter deetl Director: 6 ☐ Could not be datarmined 3 Suicida Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, streal, factory, offica building, atc. (Specify) 4 Homicida Hospital 24 hours e Funeral D 29a. Cartifian 1 🔀 Cartifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. (Check only 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title of certific 29c. Licanse number 29d. Data signed (Month, Day, Year) 0003588 30. Nama and addrass of person who completed ceusa of daath (Itam 23a) (Type, Print) Mercy Melical Conter RONALD 31. Data filed (Month, Day, Year) JUN 1 9 2000 Registrar



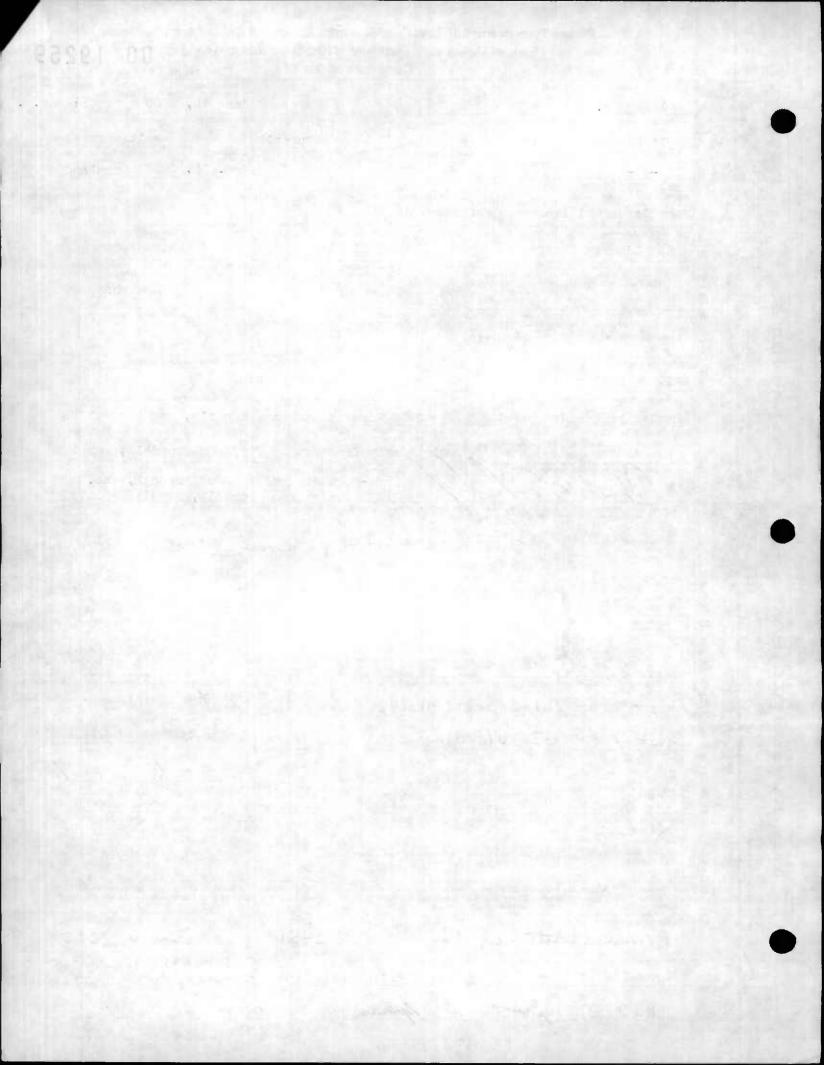
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State of Maryland / Department of Health and Mental Hygiene

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				Cer	tificate	e of	Death			Reg. No.		
T. 7.2	1. Decedent's Nama (First, Middla, I	Last)							2. Data of De Month	ath Day	Year	3. Time of Death
Physician /Medical	Goldie B.	Arroyo					4		June 1	6, 2000		5:14 a.m.
Examiner	4a Facility Nama (If not institution, g	riva street and numbe	or)				4b. City, To	wn, or Lo	ocation of Deat	4c. Cour	ity of Deeth	1 - 1 102
	2935 Liberty Pa:	rkway						dalk		Ba	altimo	re
neral	5. Social Security Number 6		Aga (In yrs. last		If Undar Months	1 Yeer Devs		24 Hrs. Min.	8. Deta of Bir (Month, Da	iv. Year)	9. Birth	placa (State or Foraign ntry)
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eted by Funeral Director	Usual Rasidence of Decedant  10a. Stata  10b. County		10c. City, To	own or Lo	cetion		····			-		10d. Insida City Limits
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i e	10a. Street and Number				10f. Zlp	Code	11.5			10g. Citizan o	What Cou	ntry?
<u>=</u>	2935 Liberty Pa	rkway			21	222				Unite	ed Sta	ites
Funeral Director	11. Marital Status	12. Was Decedar Armed Forcas	nt Evar in U,S.	13. \	Vas Deced	dent of I	Hispanic Or	igin? (Sp	ecify Yas or No Rican, atc.)	- 14. R	aca - Amari lack, Whita	
	1 Nevar Married 2 Married				Yas a				Thour, ato.,		ity: Whi	
i by	3 ☐ Widowed 4 ☐ Divorced	Year or Detas	s:			22110	ороспу.			Spec	му. ****	
Completed	15. Decedent's (Specify only highast)		1	6a. Deced	lent's Usua kind of wor	al Occur	pation during mos	t of work	ing	16b. Kind of	Businass/In	dustry
du	Elementary/Secondary (0-12)	College (1-4o	or 5+)				ed)					
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Be	17. Fathar's Nama (First, Middla, La	st)							a (First, Middle.	, Meidan Sum	ama)	
2	Allen Butzler						Emm	a Dr	ebing			
	19a. Informent's Neme/Reletionship	(Type, Print)	1	19b. Mailin	g Addrass	(Stree	t end Numb	er or Rur	al Routa Numb	er, City or Tox	ın, Stata, Zi	o Coda)
	Carlos Arroyo (	Husband)					Park	way	Dundal			
	20a. Mathod of Disposition 1 ⊈Burial 2 ☐ Cramation 3	Demousi from Stat	came	of Dispo	sition (Nan natory or o	na of ther pla	ica)		Data	20c. Locatio	n - City or T	own, Steta
	4 Donation 5 Other (Special		Holy	Ros	ary C	eme	tery	6/	19/2000	Dunda	alk, N	Maryland
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8	1/1/2/11	V/-/2	1/						Home of			
	23a. Part1. Enter tha diseasa, or co	mplications that caus	ad the death. D						Dundalk		Land 2	Approximata
an	shock, or haart tailura. List on	ly ona causa on aach	liria.									Interval Batween Onsat and Death
al	Immediate Cause (Finel	alana	in al	م د لم		10	0.1		1.0	8000		019 1/01 10
r	diseasa or condition resulting in death)	a. Curo	nic ob	STVI	ACTIL	12	pulm	Ma	cy ais	ease	1	one year
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3	C. 100 (100 (100 (100 (100 (100 (100 (100	d										
clar												
ysi	Part II. Other significant conditions	contributing to death	but not rasultin	g in tha u	nderlying c	ause gi	ivan in Pert		2/			to the cause of death?
by Physician	history of	Julmonai	ny em	60/4	S				1/25	Yes 2 No	3 □ Pro	obably 4 Unknown
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ert	4 LI nornicide	building,	etc. (Specify)						City or 10	en, Statel)		
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×	29b. Signatura and titla of certifier				290	. Licen	sa number			29d. Data sig	ned (Month	, Day, Year)
	> Michael W	etterman	M.D.		1	) 5	245			June	16	2000
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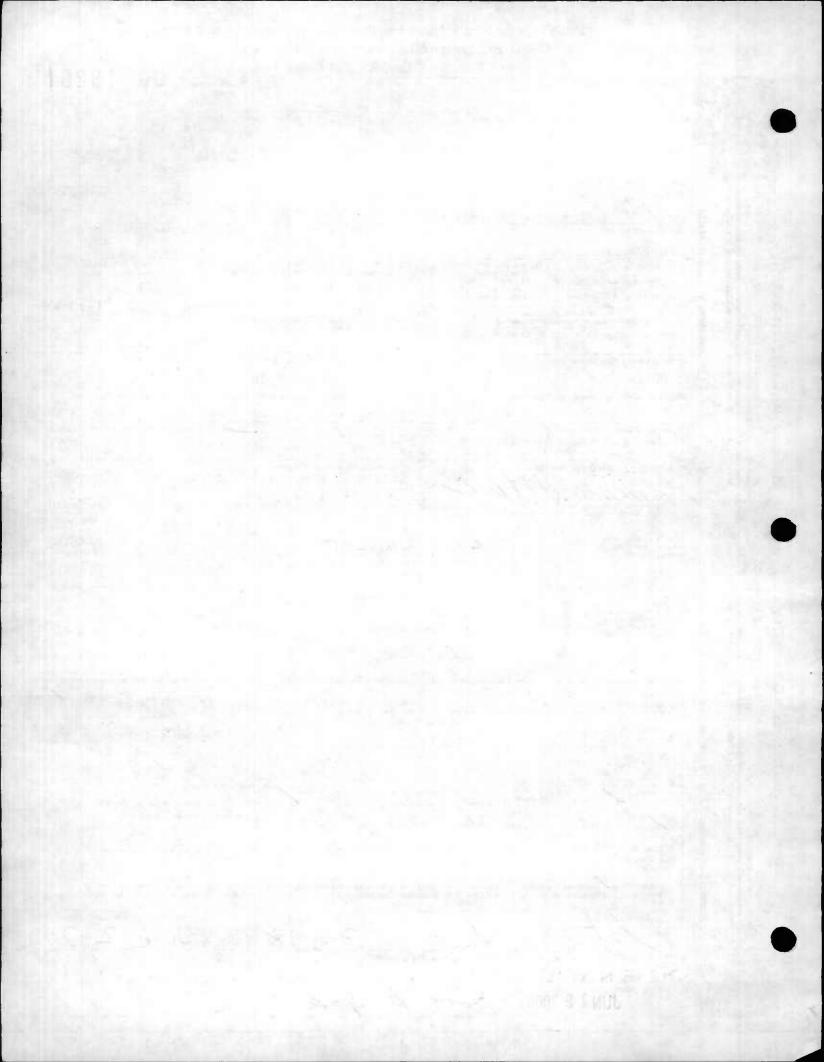
State of Manuard / Department of Health and Montel Hugings

	1. Decedent's	Name (First, Middl	le, Last)					Death		2. Date of De			3. Time of Dec
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	5. Social Secu		6. Sex	7. Ag	ge (In yrs. last.	birthday) Yrs.	If Under 1 Year Months Days	r If Under	A111 1	8. Dete of Bi (Month Di Novembe	rth	9 8	Birthplece (State or Fo
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Director	10e. Street an		11. *	+ 0074			101. Zip Code	006	711			n of What (	
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2	1 Never	Merried 2 Man	ried 1	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Yaar or Dates:			13. Was Decedent of Hispanic Origin? (Splif Yas, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:			o Rican, etc.)  Bleck, \ Specify:		Bleck, Wh	
		15. Deceden (Specify only higha			16	6a. Decede	nt's Usuel Occu ind of work done O NOT use retin	pation during mo	st of workin	g	16b. Kind	of Busines	ss/industry
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		nt's Neme/Relations					Address (Street						e, Zip Code)
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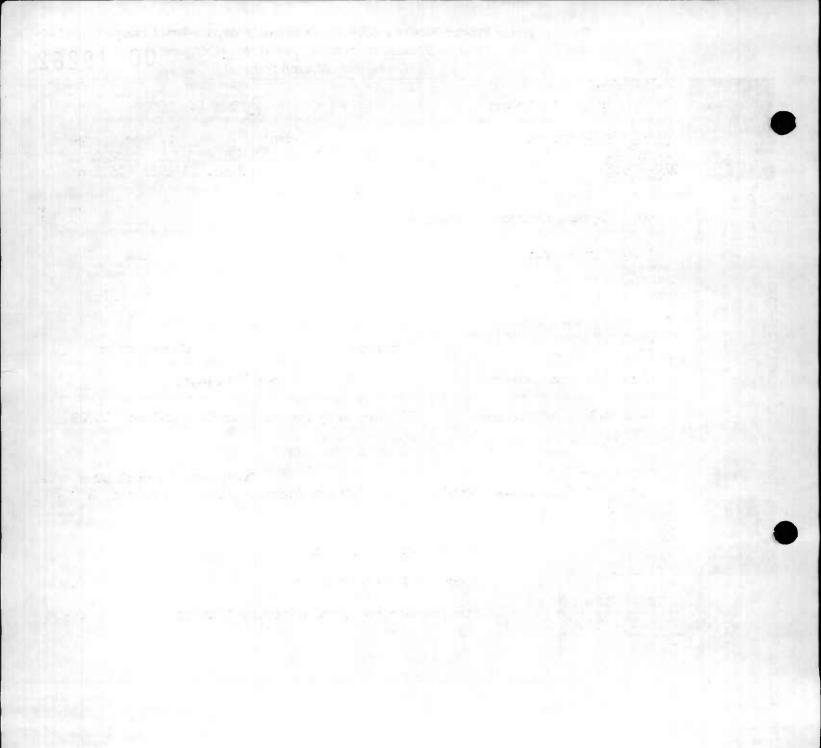
	Certificate of	Death	Reg. No.	02611
/sician	1. Decedent's Name (First, Middle, Last)		of Death Day 2000 Year ne 10, 2000	3. dime by leath
ledical	Mary E. Allan			5:20 PM
aminer	4a Facility Name (If not institution, give street and number) Wilson Health Center	4b. City, Town, or Location of Gaithersburg	Montgon	
	5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday) Months Deyr	r If Under 24 Hrs. 8. Date s Hours Min. Apr	of Birth 9. Birth th, Day, Year) Co	hplace (Stete or Foreig untry) anada
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
tor	MD Montgomery Gaithersburg			1 □ Yes 2√2 No
<b>Funeral Director</b>	10e. Street and Number 10f. Zip Code	1	10g. Citizen of What Co	untry?
le l	301 Russell Avenue	20877	USA	
Š	11. Meritel Status  1 Never Married 2 Merried  3 Widowed 4 Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  1 Yes, Specify Cu  1 Yes, Gwe Year or Dates:	Hispanic Origin? (Specify Yes ban, Mexican, Puerto Rican, et o Specify:	c.) Black, White	
	15. Decedent's Education 16a. Decedent's Usual Occ (Specify only highest grade completed) (Give kind of work don	e during most of working	16b. Kind of Business/	Industry
	Elementary/Secondary (0-12) College (1-4or 5+)  12 4 housewife	9d)		
	12 4 housewife 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	none  fiddle, Maiden Sumame)	
	Tom Thomas	Jessie Gr	rant	
		ne Mason, OH		ip Code)
	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State  4 ☑ Donation 5 ☐ Other (Specify)  20b. Place of Disposition (Neme of cemetery, cremetory or other pi	Date	20c. Location - City or	Town, State
	A INDONALL AND A CONTRACT OF THE ACTION OF T	atomy Board 655	W. Baltimore	Street
7	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dishock, or heart feiture. List only one cause on each line.	e, MD 21201 ring, such as cardiac or respire	tory arrest,	Approximate Intervel Between
	the state of the s			Onset and Deeth
	Immediate Cause (Finel disease or condition resulting in death)  a. Dreast cancer			Years
10	Due to (or as a consequence of):			
Examine	Sequentially list conditions  Due to (or as a consequence of):		t t	
edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last  Due to (or as a consequence of):  Due to (or as e consequence of):			
HOIGHAM	d.  Pert II. Other significant conditions contributing to death but not resulting in the underlying cause of	riven in Pert I. 23b	. Did tobecco use contribute	to the cause of death
Physician				robably 4 Unknow
Completed by		24a.	performed?	Were autopsy findings available prior to completion of cause
E O				of death? 1 □ Yes 2 □ No
9	25. Was case referred to medical	26. Place of Deeth (Check		10105 2010
10	examiner? 1   Yes 2   No	ther	Residence 6 Other (Spec	cify)
	2   Accident	ury at 28d. Description	cribe how injury occurred	
2			tion (Street and Number or Ru or Town, Stete)	iral Route Number,
Certifica	3 ☐ Suicide 4 ☐ Homicide  Could not be determined  28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			
edical Certification:	determined   200. Place of Injury - At nome, ferm, street, fectory, office	time, date and place, end due t opinion, deeth occurred at the	o the cause(s) and menner as time, date and place, and due	stated. to the cause(s)
Medical Certifica	Homicide  determined  289. Place of injury - Ar nome, ferm, street, fectory, onto building, etc. (Specify)  299. Certiflier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred et the Check only one)  1 Medical Examiner: On the basis of examinetion and/or investigation, in my and manner stated.	time, date and place, end due to opinion, deeth occurred at the assenting to the opinion of the occurred at th	to the cause(s) and menner as time, date and place, and due	to the cause(s)
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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O.O.

		1. Decedant's Nan	na (First, Midd	lie, Last)						Death	2. Data of D			3. Tima of Dea
Physic			Peter	. A.	Anders	on					June 1	4, 2000	Yaar	7:10 r
/Medi Exami		4a. Facility Name (							4	b. City, Town, o	Location of Dea	-	of Daath	7.10
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r 28	Director	10e. Street and Nu		.e_	orge	LIC	urer	10f. Zip (	Code			10g. Citizen of	What Country	17
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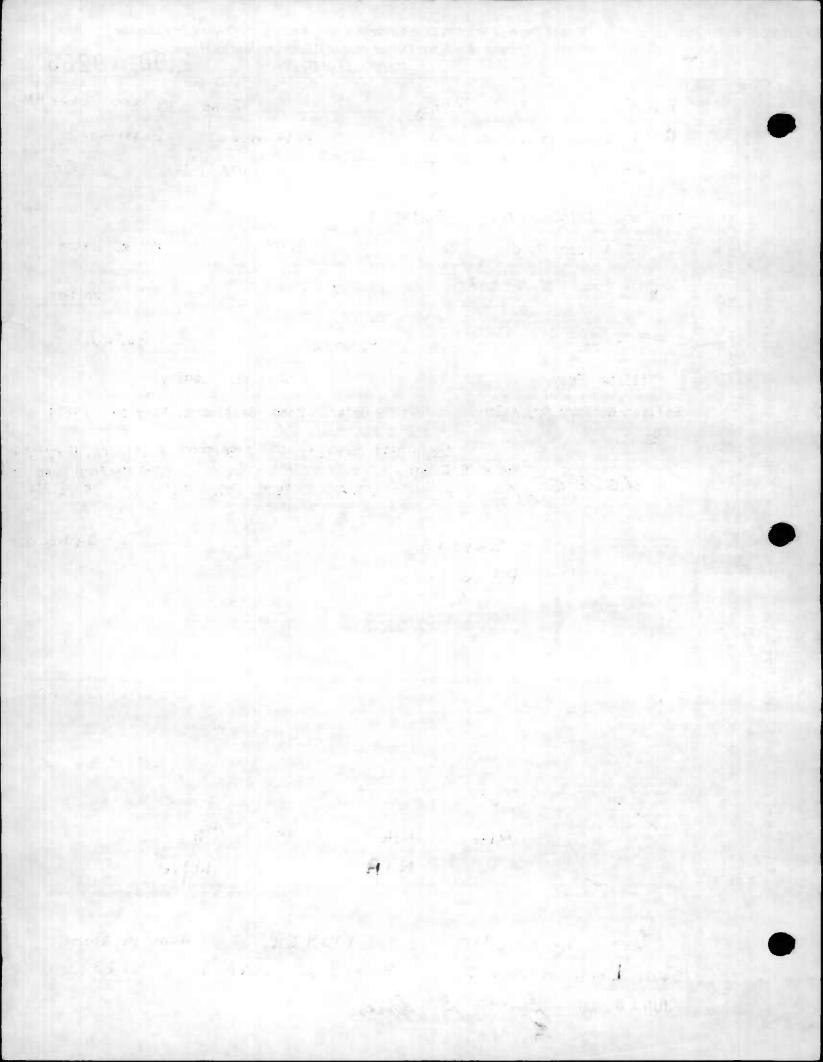


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yee Month **Physician** 8:31 AM Elsie 2000 June 17 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Baltimore Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 ■ M 2 XF 85 Yrs. 220-36-9462 Director May 1, 1915 Maryland Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23s or 28s-1 show other traumstic event, the Modical Examinal must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Co. Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 United States 2621 Windsor Road permit. Pages 1 and 2 should be filed within 72 hours effer death a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23, any injury or other traumatic event, in a Medical Experient male Funeral 14. Rece - American Indian, Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No It Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 □XWidowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Yrs. Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be William Frey Rose Ann Lenivy 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William G. Bory, Sr. / Son 1708 Orlando Road Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 6/20/2000 Baltimore, Maryland Cedar Hill Cemetery 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Fecility 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physiclan** Immediate Cause (Final disease or condition resulting in death) /Medical 24 hours Sepsis **Examiner** Due to (or as e consequence of) Examiner Pneumonia sician and bunal-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequenca of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): certificate has been signed by the irrector, page 2 should be deteched Part If. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 1 Unknown þ 24b. Were autopsy findings aveileble prior to completion of cause of deeth? Completed 24a. Was an autopsy 1 ☐ Yes 2 PNo 1 □ Yes 2 No director, Be 25. Was case referred to medical 28. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this After this funeral of 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Neturel death. 1 ☐ Yes 2 No MIA 2 Accident MIA MIA efter death Director: / 6 Could not be determined n 24 hours efter dea ne Funeral Directo pletely filled in by th 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide NIA N Hospital edicai 29e, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner es steted. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. within 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 June 17, 2000 13454 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Maryland 21239 Baltimore Raven Blud 5601 Loch 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

JUN 1-9 2000



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Physician 7:15pm JUNE EdWARD DENTAMIN /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON If Under 24 Hrs. 8. 1 GILCrest VUrSING Home If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 5. Social Security Number Sax 12 M 2 F **Funeral** Days 218-05-7449 Yrs AUGUST 24, 1918 MARYLAND Director Usual Residence of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo ma BALTIMORE DUNPALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Searles ViseA. Funeral 12. Was Decedant Evar in U.S. Armed Forcas? 1 Eves 2 DNOS 15 FM If Yas, Giva Yaar or Datas: 0 FJ 1945 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status 1 Navar Married 2 Married 1 ☐ Yas 2 PNo Specify: specity: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) ould be filed within Mental Hygiene. Elementary/Secondary (0-12) Coilega (1-4or 5+) STEEL FOREMAN 8415 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) HAREY MARGARET 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1974 Searles Rl DundAK MD 21222 20b. Place of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata Department of Important: If Its 1 Burial 2 Cramation 3 Ramoval from Stata 8 6/19/2000 OWINGS MIUS MO 21117 Forest V.A. Cemeter 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility 7110 Soller Pt Rd Cowelly Fiver Hore of Dustalk DUNDARK MAD 2122 23a. Part1. Entar the disease/or complications that caused the death. Do ot antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final AnomA 4 months disassa or condition rasulting in death) **Examiner** Examiner Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequenca of): Physician/Medicai Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown Division of Vital Records. Completed by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Medical Certification: To Be 26. Placa of Daath (Check only ona) Hospitai: Other: 4 Nursing Homa 5 Residence 6 Styles (Specify) 10501 1 Yas 2 PNo 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c, Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of After ! or Attending 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No To the Hospital or Attendit 2 Accident 6 Could not be determined 281. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only 29b. Signature and little of on 29c. Licansa number 29d. Data signed (Month, Day, Year) who completed cause of death (ftam 23s) (Typa, Print) hales St. Begistrar's Signatura 31. Date filed (Month, Day, Year) State Registrar JUN 1 9 2000 DHMH 16 Rev 6/95

**ORIGINAL** 

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** 2000 JUNE 16, NICHOLAS ANGELO BARILLA 9:26 A.M. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 23566 KEEN RD. CHANCE SOMERSET 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) NOV. 11, 1935 8. Birthplace (State or Foreign Country) PENNSYLVANIA 7. Age (In yrs. last birthday) **Funeral** 180 M 2□ F Days Hours 64 Yrs. 212-34-3387 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Phylane. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show with fulury or other traumatic event, the Medical Evantment must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND SOMERSET CHANCE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23566 KEEN RD. 21821 UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 No Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, White, etc. 11. Meritel Stetus 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 If Yes, Give Yeer or Detes: 1958 1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) DIR. OF LOSS PREVENTION **GROCERY** 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) NICHOLAS MICHAEL BARILLA MARY CARBE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY SUE BARILLA / WIFE 23566 KEEN RD., CHANCE, MARYLAND 21821 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete JUNE 20 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 Donetion 5 Other (Specify) CREST LAWN MEM. GARDENS 2000 MARRIOTTSVILLE, MARYLAND 21. Signature of Runera Service Li 22. Name end Address of Fecilit KIRKLEY-RUDDICK FUNERAL HOME, P.A. 0 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart leiture. List only one cause on each line. Approximete Interval Betwee Onsetjand Dee **Physician** Lung Cancer tmmediete Cause (Finel diseese or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Dua to (or as a consequence of): The law requires that the death certificate be exe Records, P.O. Box 68760. Dua to (or es a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? D'seare 1 Yaa 2 No 3 Probably 4 Unknown Jonasc 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital or Attending Physician: 88 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 20100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ä 27. Manger of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Attor 1 ANatural 2 Accident 5 Pending investigation 1 Yes 2 No To the Hospital or Attend within 24 hours after death To the Funeral Director; A completely filled in by the I 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

State Registrar

**DHMH 16 Ray 6/95** 

29b. Signature and fittle of certifier

31. Dete filed (Month, Day, Year)

30. Nerpe and address of person who completed cause of deeth (Item 23a) (Type, Print)

TODNEY

JUN 1 9 2000

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LAYTON

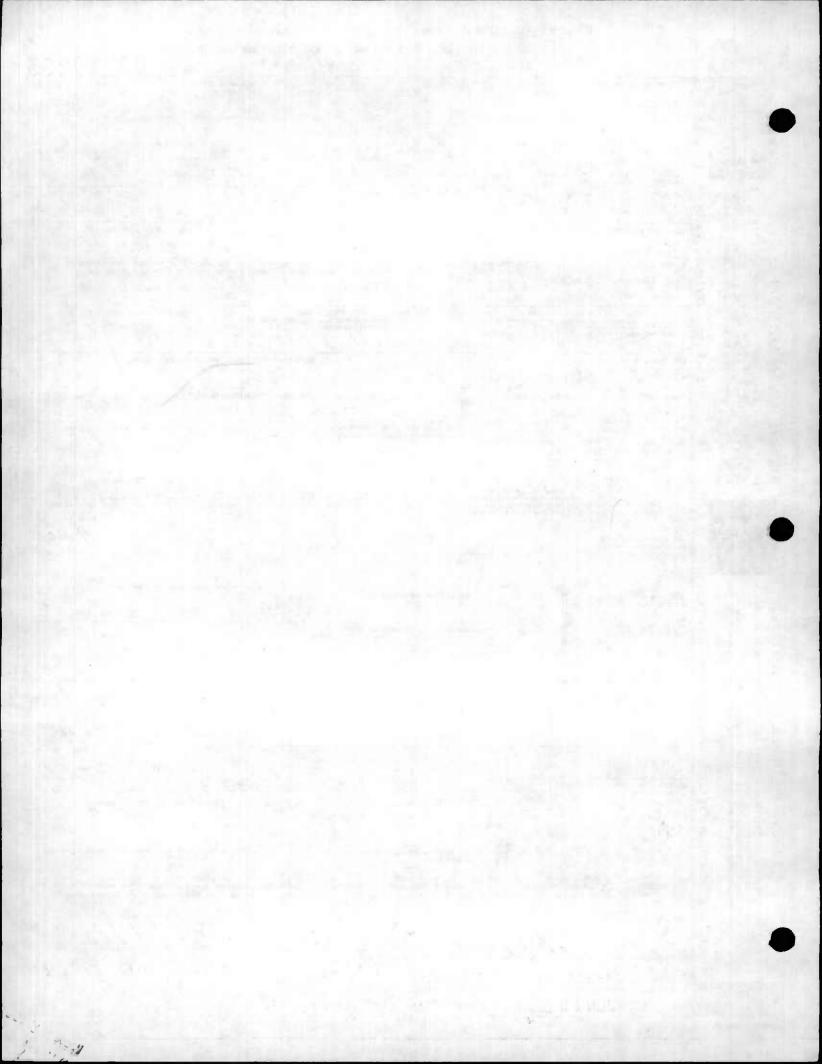
32. Registrar's Signeture

29ç. License number

13222

SALISBURY

29d. Date signed (Monty, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 19266 Certificate of Death Reg. No. 1. Decident's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year AMES MATA 45AM 10a) MAN SWE 2000 /Medical 4a. Facility Name (If not Institution, give street and number) City, Town, or Location of Death 4c. County of Deeth Examiner LYNdON WAUGH TIMORE 6. Sex 1 → M 2 → F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July /, 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) Maryland **Funeral** Days 218-01-6117 83 Yrs. Director Usuel Residence of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yea 2 No Director Maryland Baltimore G1 yndon 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21071 19 Waugh Avenue U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 (XYes 2 □ No tf Yes, Give Yeer or Dates: WW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WW II À Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Contracting Carpenter permit. Pages 1 and 2 should be filled v
Department of Health and Mental Hygies
Important: If item 27 is marked other it
any injury or other traumatic event, Item 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James M. Bowman, Sr. Julia Berwager 19a. Informent's Name/Relationship (Type, Print)
Mrs. Elizabeth Bowman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Wife 19 Waugh Avenue Glyndon, MD 21071 20b. Placa of Disposition (Name of cemetery, crematory or other place)
Leister's Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removal from State 6/21/00 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22 Name end Address of Fecility Eline Funeral Home 11824 Reisterstown Road Reisterstown, luce MD 21136 Paint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, such, or heart tailure. List only one cause on each line. Approximete Interval Between Onaet and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical TO HANGING Examiner Due to (or es e consequenca of): Physician/Medical Examin ician end buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. certificate be thet Due to (or as a consequence of) 89 for use es P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ HO 1 TYes 2 No of Vital or Attending Physician: director, Be 25. Wes case referred to medicat 26. Ptece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Ves 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this er death.
rector: After this
by the funeral d 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Division 5 Pending investigation 1 Natural fnjury HANGED 9 A SURE 17,2006 1 ☐ Yes 2 ☑ No 2 Apcident 6 Could not be determined 3 Suicide Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide GLYNDON 19 WAV9 HAVENUE

10 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) marylon 29a. Certifier edical (Check only one) and menner stated. 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) REDER FOX Pd -CATONSVILLE 111,AmSUNT 05 31. Date filed (Month, Dey, Year) State 32. Registrar's Signature MAR92 RON 21228 Registrar

**DHMH 16 Rev 6/95** 

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 6:30p.m Month. **Physician** 06 00 /Medical 4b. City. Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) **Examiner** ELKRIDGE Meadownage Road Balto If Under 1 Yeer | If Under 24 Hrs. | 8. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys 20 F 214-16-7486 Yrs. Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 No Ba RLICRID GE or 25a-f s be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 633 eadowridge Road 21075 4.5 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: if Idem 27 is marked other than "natural", or its Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working title. DO NOT use retired) 16b. Kind of Business/Industry UNIL 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 tharade NA Janitorial 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be is marked Blackstone Wilson Henry John ourse 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 210 75 6332 1eadowridge Blackstone Road -Wite Elkridge, Md 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Department of 1 Buriel 2 □ Cremetion 3 □ Removel from State 17-00 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility (So) 21. Signature of Funerel Service Licensee Md 21215 Bac Ho. Avenue Part. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) COLUZ CANCEN 44411 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? Records, P.O. 1 ☐ Yee 2 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? STANS 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? å 26. Plece of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Sesidence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Division of all a 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 5 Pending investigation or Attending Natural death. 1 ☐ Yes 2 ☐ No 4 hours after death Funeral Director: / 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Roufe Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 24 hours Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hours To the Funs completely to (Check only one) 29b. Signature The of Certif 29c. License number

State

Registrar

30. Name and address of

31. Dete filed (Month, Dey, Year)

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**DHMH 16 Rev 6/95** 

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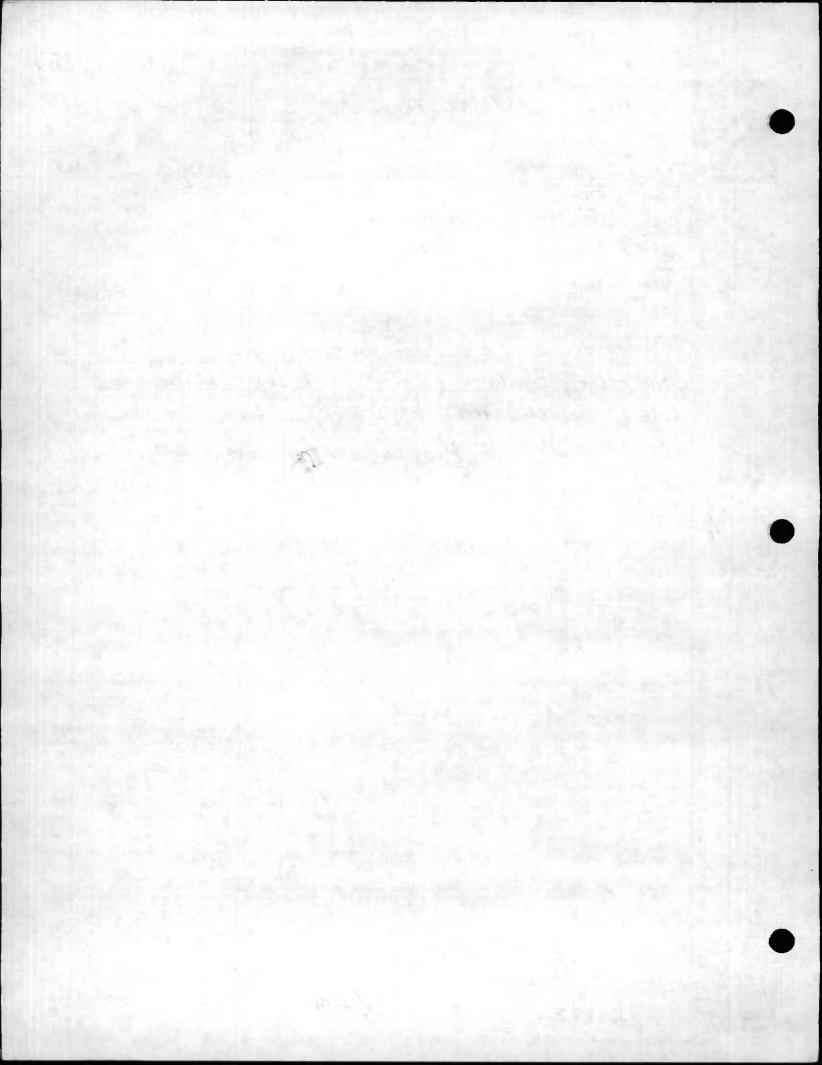
ed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

**ORIGINAL** 

29d. Date signed (Month, Dey, Year)

Columbia



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** CONNOR JUNE X1458 WILBUR 2000 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner rs. 8. Date of Birth a If Under Months 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 218-14-7924 Days 1 M 2□F Hours Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 XYes 2 □ No Funeral Director 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 5 2 OX 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Stetus Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 0 21215-0020 1 Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Trican 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondery (0-12) College (1-4or 5+) riar d altimore, Maryland permit. Peges 1 end 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other treumatic events Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es onnor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 122 20b. Place of Disposition (Name of 20a. Method of Disposition

1 Burial 2 □ Cremation Date 20c. Location - City or Town, State netery, crematory or other place) 3 Removal from State 4 □ Donation 5 □ Other (Specify) ure of Funeral Service/Licenses 22. Neme and Address of Facility S Joseph uneral tom 2222 W. North Balto. 2/2/6 Ave. or the grease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the first cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final 0.5 has ARRYTHMOLAS CARDIAC disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner 5.0 ms SEPTIC SHOCK The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. RENA2 DISEASE UNKNOWA END STAGE 21 HEART DISEASE ARTERIOSCLEROTIC esn. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETEL MELLITUS Records, þ 24b. Were eutopsy findings evaileble prior to completion of cause of death? Be Completed 24a. Wes en autopsy performed? HYPERTENTION 24 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitai: edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred or Attending 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a
To the Funeral C
completely lilled To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 23300 JUNE 13 2000 ND. BON SECUNRS HOSP. 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) PATEL BALT 1 3T. SUDMIR. 2000 W. BALTO, MD.

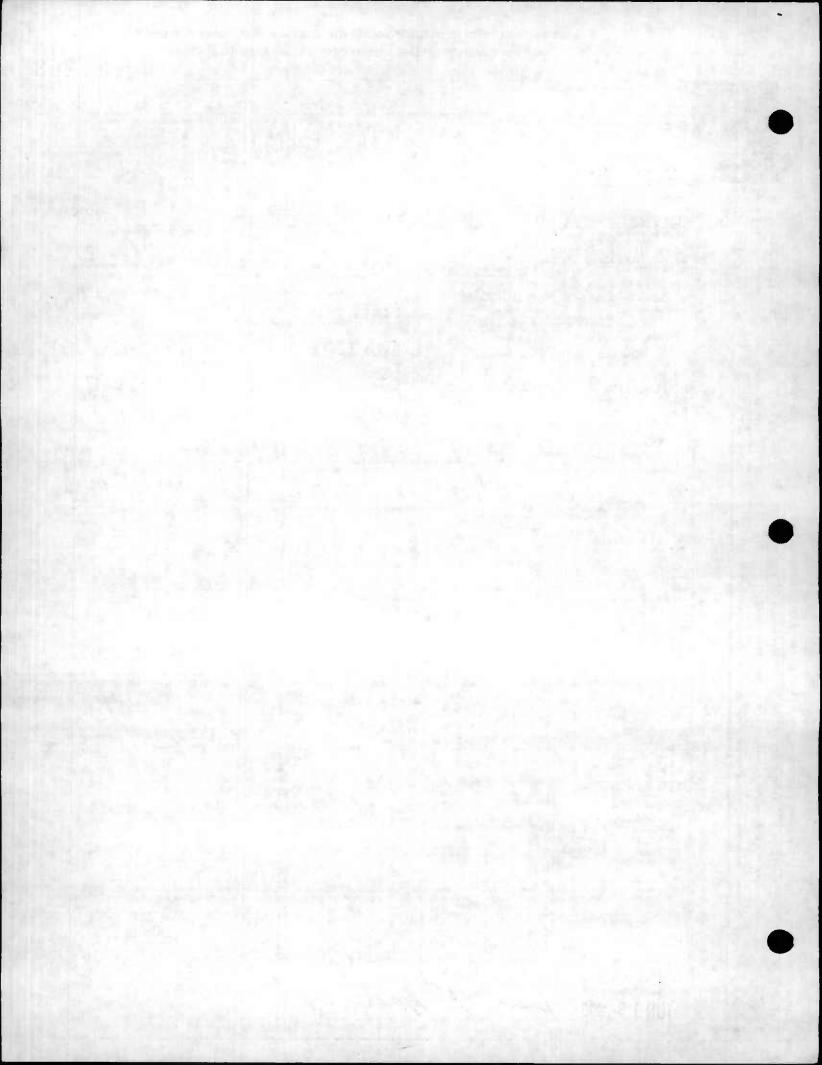
Registrar

31. Date filed (Month, Day, Year)

1 9 2000

DHMH 16 Rev 6/95

32. Registrar's Soneture



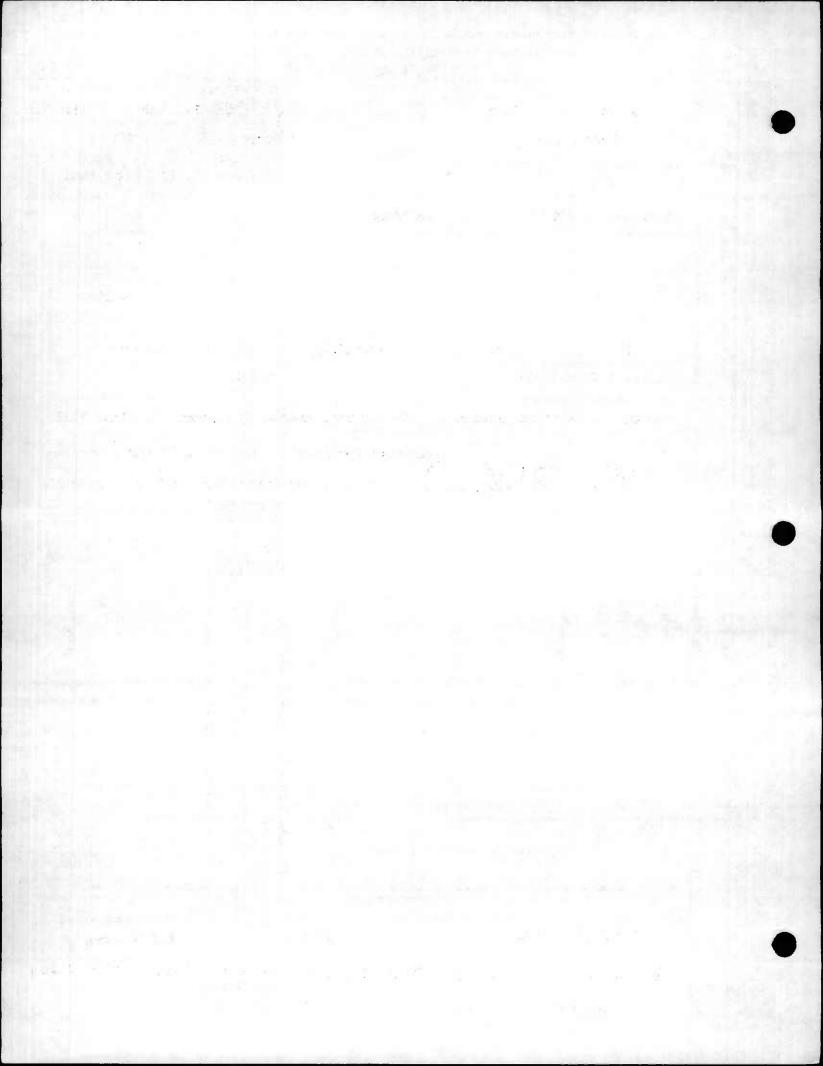
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dele of Death Month **Physician** Yaa June 14, 2000 /Medical Robert Codd 11:55 AM 4a. Facility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Roland Park Place Baltimore N/A 830 W 40th Street If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Year) if Under 1 Yaar 5. Sociei Sacurity Number 7. Age (In yrs. last birthday) Birthpiece (Stata or Foraign Country) **Funeral** 1₩ 2□ F Days Months 133 - 10 - 6859 Director Aug 28, 1913 | Maryland Usual Rasidanca of Decedant with the Maryland 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be retified at 10d. inside City Limits XX Yes 2 □ No Directo N/A Baltimore Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? USA permit. Peges 1 and 2 should be filed within 72 hours effer death v. Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23 any highry or other traumatic event, the Medical Exercises once. 830 W. 40th Street 21211 Funeral 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedani of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Maritai Staius 14. Race - American indien. Black, White, etc. 1 Navar Married 2 Merried GYes 2□ No fYes, Giva Baltimore, Maryland 21215-0020 1□ Yes 2□ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Coilega (1-4or 5+) 12 4+ Electrican Research 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Edward Codd Edith James ပ 19a. informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) E. Moffett Friend Baltimore, Maryland 21221 Robert 416 Maryland Avenue 20b. Placa of Disposition (Neme of cematary, crematory or othar place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Removel from Stata Greenmount Cemetery 6/16/00 Baltimore, Maryland 21. Signature of Funerai Service Licens 22. Name end Addrass of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest.

Maryland shock, or heer failure. List only one cause on each line. Approximeta Intarval Between Onsat and Death **Physician** /Medical immediata Ceusa (Final diseasa or condition resulting in deeth) Bladden Cancer Examiner Dua to (or as a consequence of): Physician/Medicai Examiner ettending physician end for use es the burief-transit requires that the deeth certificate be exacuted Sequantially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or injury that killing and entarts) Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, thai Initiated evants rasulting in death) Last Dua to (or as a consequence of) Part il. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown betructive Pulm þ 24b. Wara autopsy findings available prior to completion of causa of daath? Completed 24a. Was an autopsy performed? Hypothymidisn certificate has 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cardifica completely filled in by the funeral director. 25. Wes casa referred to medical examinar? Be 26. Placa of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residance 6 Other (Spacify) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No P 27. Mannar of Deeth 28a. Data of injury (Month, Day Year) 28c. injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: 5 Panding invastigation 1 Naturai 1 Yas 2 No 2 Accidant 3 ☐ Suicida 6 Could not be datarmined 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28a. Piece of injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) end menner es stated.

2 Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, deeth occurred at tha tima, data and place, and due to the cause(s) end manner stated. 29a. Certifier Medical 29b. Signeture and title of certifier 29c. License number 29d. Deie signed (Month, Dey, Year) mo 30. Nema and addrass of person who complaied causa of daath (item 23a) (Type, Print) Drive + 209 Tunion MD M.D 7600 Hunna 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar JUN 1 9 2000

**DHMH 16 Ray 6/95** 



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** Mary E. Carter June 13, 2000 9:00 PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3838 Roland Avenue Baltimore N/A Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Director 94 224-60-7370 March 17,1906 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow. if then "natural", or items 23s or 28s-f showing Medical Examiner must be notified at XX Yes 2 □ No Director N/A Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3838 Roland Avenue Apt 1111 21211 USA Funeral 14. Raca - American Indian, Black, Whita, etc. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Accountant Federal Government permit. Pages 1 and 2 should be flit Department of Health and Mental Hy Important: If Nem 27 is marked oth any linury or other traumatic event potes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Mary E. Herbert Wilkins Lambert 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21211 19a. Informant's Name/Relationship (Type, Print) James E. Carter 3838 Roland Avenue # 1111 Baltimore, Maryland Husband 20b. Placa of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date Place of Disposition (remetery or other place) cometery, cremetery or other place) Crematory 6/15/00 Laurel, Maryland 1 Burial 2 Cremation 3 Removal from State 4 Donation S Other (Specify) Baltimore-Washington 21. Signature of Huneral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland Approximate Intervel Between Onset and Death nter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the second of the cause on each line. **Physician** /Medical Immediate Causa (Final 100 disease or condition rasulting in death) Examiner Due to (or as a consequenca of) Examiner physician and s the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequenca of): Physician/Medical Dua to (or as a consequance of): USB BS signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of death? been si 24a. Was an autopsy performed? Completed has page 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Hospital: 1 Yes 22 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death edicai Certification: 28a. Dete of Injury (Month, Dey Year) 28b. Tima of Injury 28c. injury at Work? 28d. Describe how injury occurred After 1 Netural 2 ☐ Accident 5 Pending investigation 1 TYes 2 No 28f. Location (Street and Number or Rural Route Numbar, City or Town, State) 6 Could not be 3 Suicida 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a. Certifier

To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funera

The law requires that the death certificate be executed

Box

Records, P.O.

Division of Vital

death with the Maryland

filed within 72 hours after

altimore, Maryland 21215-0020

md CATE

State Registrar

29b. Signature and title of certifiar

GREGORY

**DHMH 16 Rev 6/95** 

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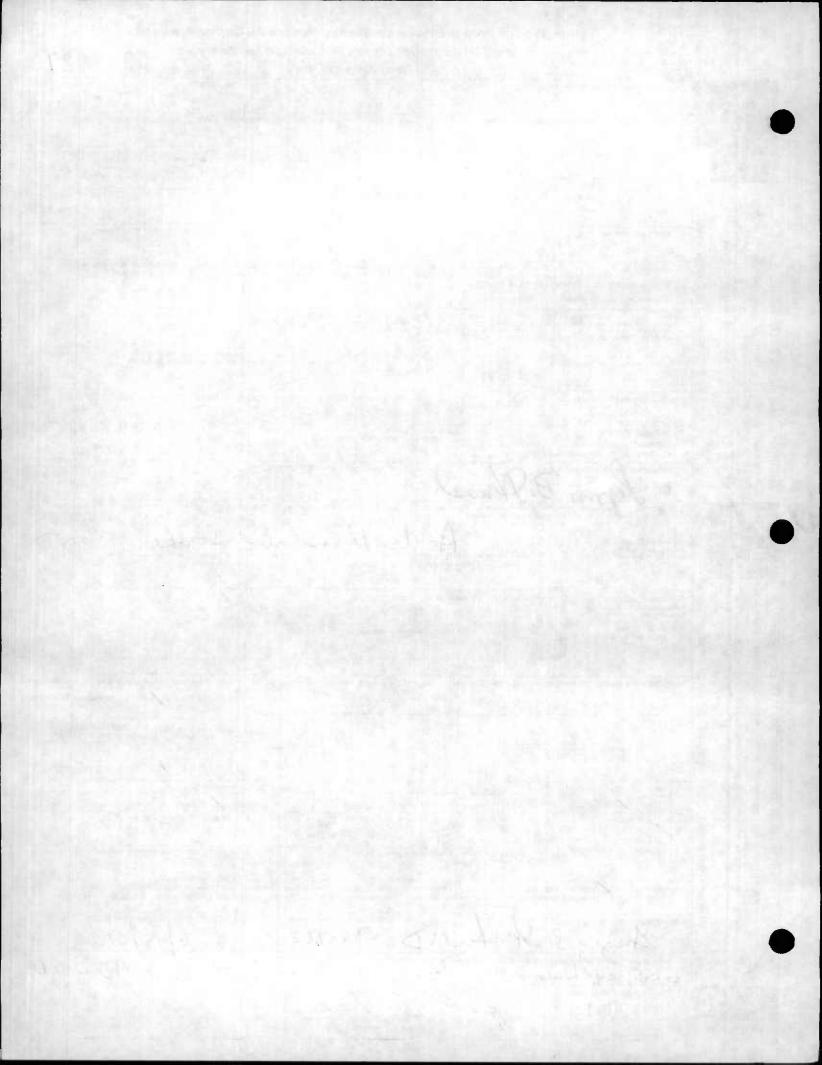
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. Licensa number

29d. Date signed (Month, Dey, Year)

St BALTOMD 21218



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** TAMES CARTER DANIEL 15, 2000 4:30 AM JUNE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7919 STONE HEARTH ROAD ANNE ARUNDEL SEVERN 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 239-30-6419 1 M 2 □ F 74 Yrs Director 22. 1926 NORTH CAROLINA Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits MARYLAND ANNE ARUNDEL SEVERN 1 ☐ Yes 2 No Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ð 7919 STONE HEARTH ROAD 21144 U.S.A. 238 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

12 Yes 2 No H Yas, Give 51 − Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) or flams 14 Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: WHITE Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 51 - 713X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 MILITARY COOK MILITARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 86 and 2 should be ealth and Mental LOUISANA BELCHER CARTER JAMES uspartment of Health and Important: If Item 27 is m any injury or other traum 2058. 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR. ALAN CARTER (SON) 1921 FOXHOUND COURT, SEVERN, MD. 21144 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 6/18/ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ST. PAUL'S LUTHERAN 4 ☐ Donation 5 ☐ Other (Specify) 2000 EDINBURG, VIRGINIA CEMETERY 22. Name end Address of FacilitySINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 1220 of omplications that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the bits Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disaasa or condition resulting In daath) Long carer to Bore and lives /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician end for use as the burlal-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of): P.O. 1 Part II. Other eigniffcant conditions contributing to death but not resulting in the underlying causa given in Part f. 23b. Dtd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed t Records, à 24b. Wera autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy page 2 s 2 TONO 1 🗆 Yes 1 ☐ Yes 2/2 No certificate Division of Vital Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1□Yes 3☑No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of tnjury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation Applied to Annual Director: Annual Oriector: Annual 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Certifying Phyetcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hospi within 24 hou To the Funer completely fil 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30-Name and addr

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

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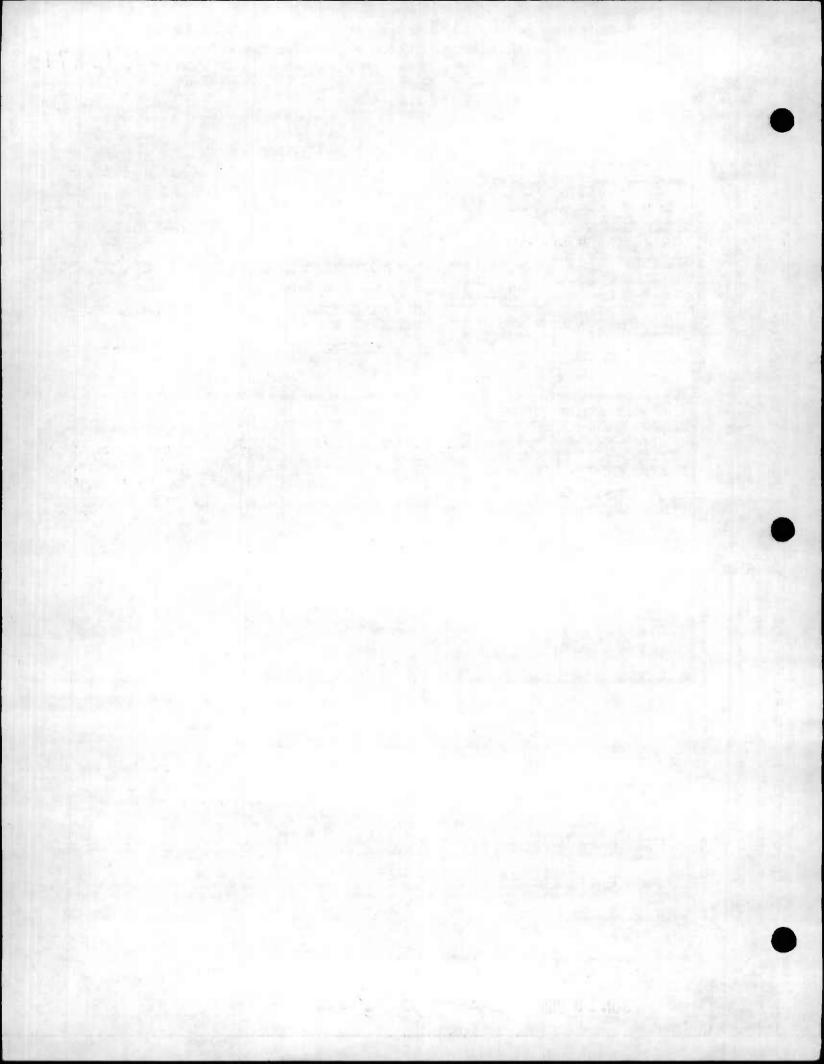
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Thway, Stefor, Efer Dunie pd. 21061

o completed ceuse of death (flem 23a) (Type, Print)

20-

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death 5 25 5 AM Day Year **Physician** MARY CRITCHFIELD Н. 15, 2000 4c. County of Death June AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) Examiner Mariner Health of Bel Air Bel Air Harford H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-30-1922 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2☑F Days Yrs. Director 218-12-3557 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits mast be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 9 Melken Court 21236 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Meritel Status id be filed within 72 hours after de lentel Hyglene. ked other than "natural", or flams is event, the Model Exemple in 1 Never Merried 2 Merried 21215-0020 White 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 yr t s College (1-4or 5+) Home Maker Own Home Baltimore, Maryland permit. Peges 1 and 2 should be file Department of Heelth and Mentel Hy important: If item 27 is marked orbit any injury or other traumatic event ablas. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Harry W. Hynson Rose C. Maenner 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9 Melken Court Baltimore, MD 21236 Mrs. M. Susan Eckhart - Daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 □ Donation 5 □ Other (Specify) Sacred Heart of Jesus 6/20/00 Baltimore, MD 22. Name and Address of Facility Baltimore, Maryland 21214 21. Signature Funeral Service License Paul Z Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Multi-infacet Dementia Immediate Cause (Finel disease or condition resulting in death) /Medical 10 years Examiner Due to (or as a consequence of) Physician/Medical Examiner physicien end the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Seizure Disorder 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? Chronic Atrial Defoto: lation certificata 1□ Yes 2 100 1 ☐ Yes 2 ☐ No funeral director. 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 27. Manner of Death 28b. Time of 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 DNetural deeth. 1 Yes 2 No 2 Accident after deet Director: 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 To the Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29e. Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number en D350/2 JUNE 15, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BelAir, Md. 21014. 2 North Ave. J. Kevin Lynch mo

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

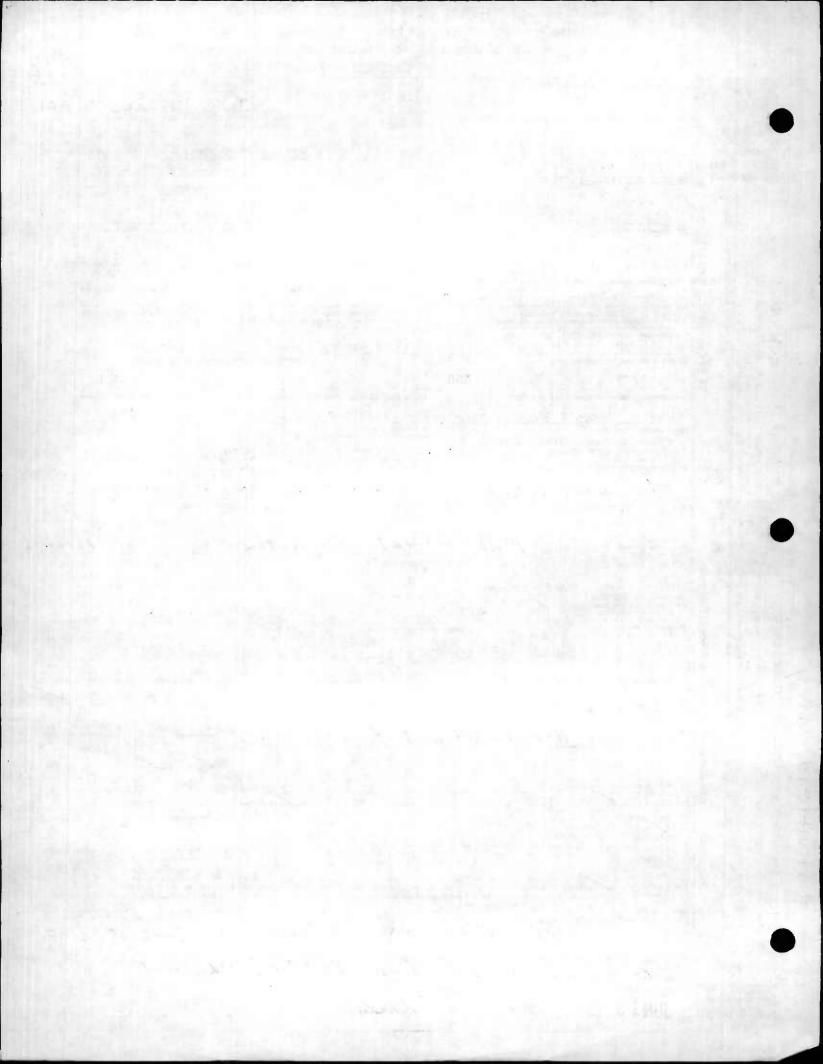
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32. Registrar's Signeture



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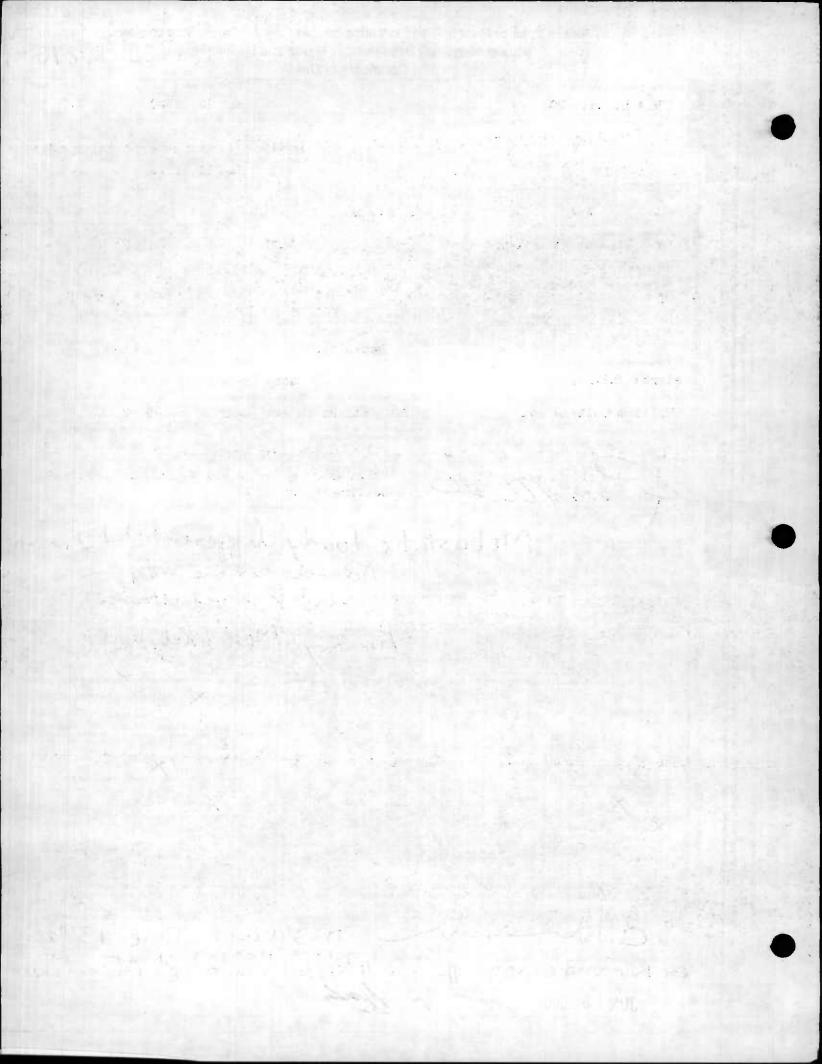
State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 30, **Physician** 2000 EULA L. COLLINS 2:00 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** 6412 Windsor Mill Road Baltimore N/A If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Months 1□ M 20 F Hours Yrs. Director 411-36-7332 74 Jan 31, 1926 Tenn Usual Residence of Decedent the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County itam 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examinar must be notified at MD N/A 1 Yes 2 No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 6412 Windsor Mill Road 21207 USA Funeral death 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or item any injury or other traumatic event, the interest and a Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: þ white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 housewife none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfred Mullins Patsy Gibson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Collins/son 3202 Elizabeth Ave Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 □ Other (Specify) Ronald S. Wade Director 22, Nama and Addrass of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Daath **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner use es the bunel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury pue ettending physician P.O. Box 68760 Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 No 3 Probably 4 Unknown signed t à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 2000 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Natural il or Attanding s efter death. il Director: Af 1 Yas 2 No 2 ☐ Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours of Funeral D edical ts Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifian 39041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300/ 5, Hand ver G. NIMA GADDA Harbor Hospital Center MD Harbor Ba nain 21225 31. Date filed (Month, Day, Year)
JUN 1 9 2000 32/Ragistrar's Signatura State

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Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 00:10 Margaret Louise Collins June 2000 /Medical 4a. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Carroll County General Hospital Westminster Carroll if Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Yaer 5. Sociei Security Number 7. Aga (In yrs. last birthday) **Funeral**  Birthpieca (Stete or Foreign Country) Deys Months 1 □ M 2 🗓 F Director 217-38-4328 Aug. 11, 1912 Tennessee Usuel Rasidence of Decedent 10e. Stete 10b. County 10c. City, Town or Location Show 10d. Inside City Limits rithan "natural", or Items 23s or 28s-f shorthe Medical Examiner must be notified at 1 ☐ Yes 200No Director Maryland Carroll Westminster 10e. Street end Number 10f Zin Code 10g. Citizen of What Country? 706 Uniontown Rd. 21158 United States Funeral 12. Was Decedent Ever In U,S Armed Forces? 11. Maritel Stetus 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American indien, Black, White, etc. o filed within 72 hours etter do I Hygiene. Other than "natural", or Item 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. þ Specify 3√7 Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired)

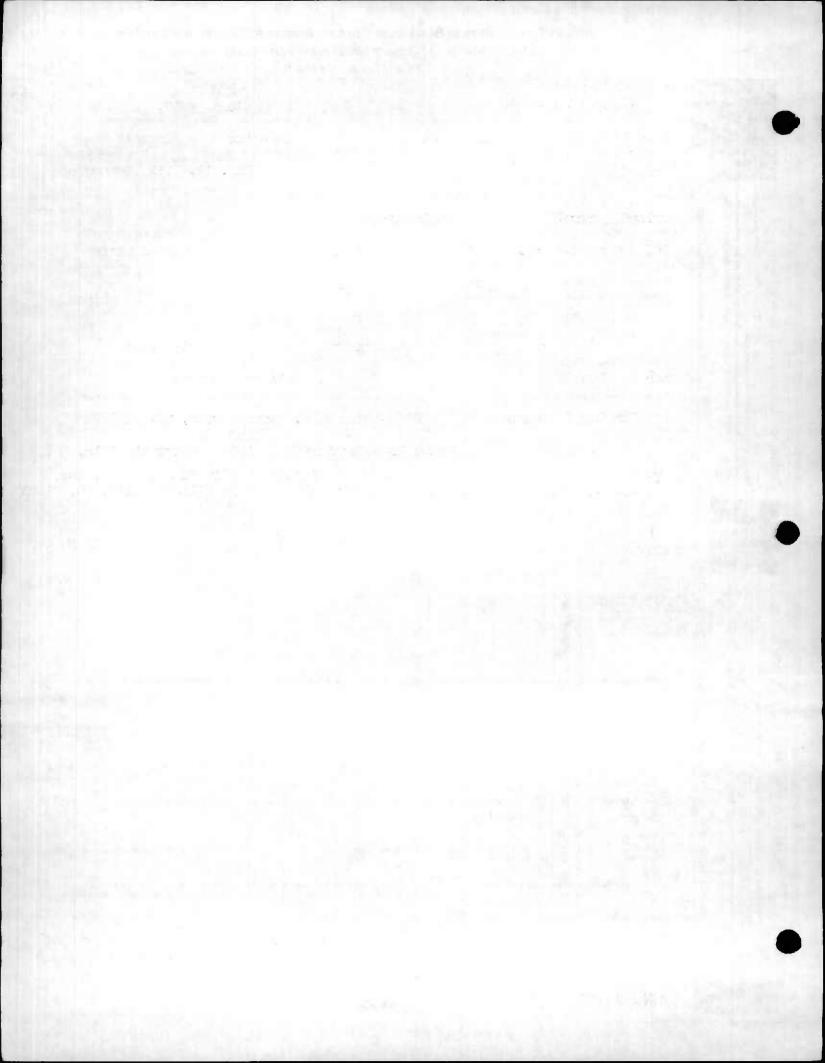
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29b. Signature end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) June, 17, 2000 D 52479 M. D 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) LISA Kim, M.D at Carroll County General Hospital at 200 memorial Avenue, Westminster, Maryland 21151

Registrar

31. Dete filed (Month, Day, Year)
JUN 1 9 2000

32. Registrer's Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9275 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE 15, <sup>Day</sup> 2000 **Physician** SHIRLEY ELLIS COHEN 5:45 AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHERRYWOOD NURSING HOME REISTERSTOWN BALTIMORE If Undar 1 Yaar If Under 24 Hrs. Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1□M 2XF 219-05-5757 Yrs. Director 80 FEB.11,1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE 280-1 BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8 3316 WILD CHERRY ROAD 238 21244 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after then of Health and Mental Hygiene.

Int. If Hem 27 is marked other than "natural", or its 1 ☐ Yes 2 XNo If Yas, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 X No Specify: WHITE P Specify: 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY SINAI HOSPITAL 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS ELLIS MOLLIE SCHECHTER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) BONNIE COHEN / DAUGHTER 200 CORK LANE #T-2, REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I Important: If Ne 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stete 6 BNAI ISRAEL CEMETERY 6/16/00 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fanerat Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** Medical Immediata Ceuse (Final disease or condition resulting in death) Examiner Examiner the burial-transit Sequentially list conditions, if any, teeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The lew requires that the deeth certificate be execu Box 68760, Physician/Medical Due to (or as a consequence of): signed by the attending p t be detached for use as Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Je5506 Records, Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? page 2 has 1 ☐ Yes 2 ☐ No 1 Yes 2 DING of Vital Physician: 25. Was case referred to medical axaminer? 80 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Aftert Division or Attanding 5 Pending investigation 1 Namel within 24 hours after death.

To the Funeral Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Secritying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

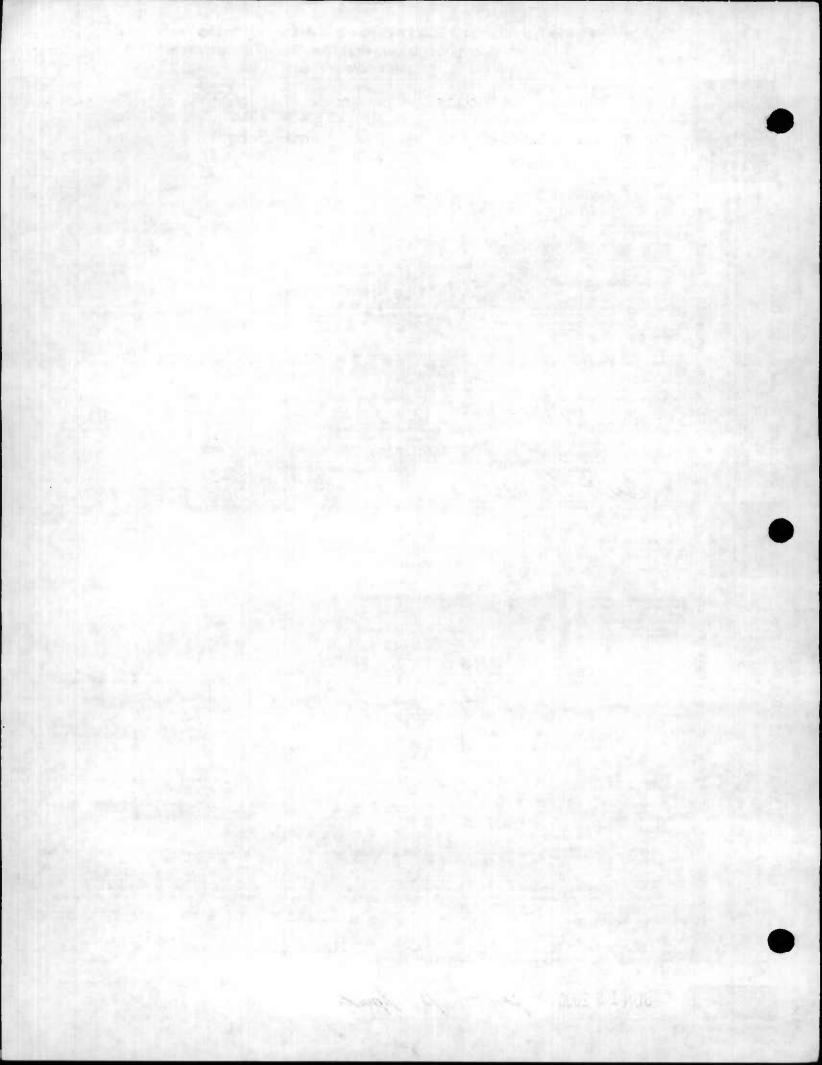
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signeture



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** nard June 2000 11 8:45 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNAPOLITAN ASSISTED LIVING ANNAPOLIS ANNE ARUNDEL 5. Social Security Number 231-05-3480 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex Birthplaca (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Yrs. Director VA 86 AUG 20 1913 Usual Residence of Decedent 10s State 10c. City, Town or Location 10d. Inside City Limits MD PRINCE GEORGES BOWIE 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 8 16014 ALDERWOOD LANE me 23a 20716 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 12 Yes 2 □ No 1943 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Stetus Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1943 ò 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Year or Dates 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US POSTAL SERVICE 12th 3 yrs. LETTER CARRIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM HENRY CAPLES REBECCA MAINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # ETHELWYN CAPLES - WIFE 16014 ALDERWOOD LANE BOWIE, MD 20716 of Health a Hear 27 la r other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page. Department of Important: If It any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal trom State GARRISON FOREST VETERANS 6-19-00 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses MARCH FUNERAL HOME WEST, INC. 4300 WABASH AVE. BALTO., MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert tellure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Alzherner's disease /Medical **Examiner** Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initieted events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco usa contributa to the causa of death? 1 Yaa 2 No 3 Probably 4 Unknown by 24b. Were autopsy tindings available prior to completion of cause ot death? Completed 24a. Wes an eutopsy 1□ Yes 2 No 1 □ Yes 2 □ No conflicate Be 25. Was case reterred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident

The law of Vital Division Attending e Hospital or Attandin 124 hours after death. e Funeral Director: Aft To the Hospital of within 24 hours at To the Funeral D completely filled

100

P.O. Box 68760.

Records,

certificate be

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

State Registrar

DHMH 16 Ray 6/95

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29b. Signature and title of certified

6 Could not be

3 Sulcide

29a. Certifier

edical

4 ☐ Homlcide

MD 32. Registrer's Signeture

and eddress of person who completed cause of death (Item 23a) (Type, Print)

28e. Placa of Injury - At home, farm, street, factory, office bullding, etc. (Specify)

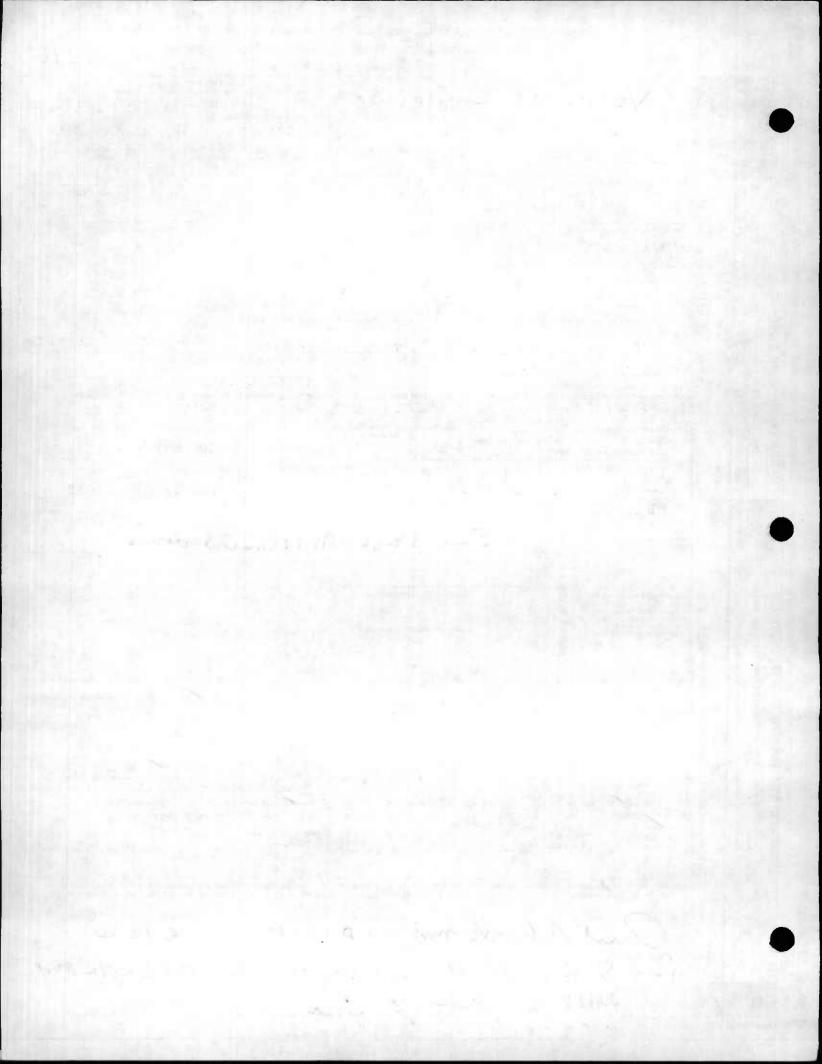
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 6-12.W

ton Center Crofton Md

28f. Location (Street and Number or Rural Route Number, City or Town, State)



## Please Type or Print in Black indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene AMEND#5 PER F.H. G784 6-21-2000 JAB Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dele ol Death 3. Tima of Death 1<sup>Day</sup>, June **Physician** HOWARD E. DERRENBERGER 2000 1:45 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Randallstown Baltimore 8. Dele of Birth (Month, Dey, Year) Feb. 16, 1912 7. Age (In yrs. last birthday) 88 Yrs. If Under 1 Year 5. Social Security Nurr 216-03-<del>929</del> 829 Birthplace (State or Foreign Country) **Funeral** Deys 10 M 20 F Feb. Director Usual Residence of Decedent the Maryland 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits wohe permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryla Department of Health and Mentel Hyglene. important: if item 27 is marked other than "natural", or items 23s or 28s-1 show entry injury or other treumstic event, the Medical Examinal must be notified at 005s. MD 1 Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7105 Rudisill Court Funeral 21244-3537 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus Types 2 No
If Yes, Give
Year or Delest 943-1946 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: white Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Emerson Warehouse T.V. Business 12 18. Mother's Name (First, Middle, Maiden Surneme)
Margaret M. Consor 17. Father's Neme (First, Middle, Last) 89 Howard L. Derrenberger 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 108 E. Chestnut Hill Ln., Reisterstown, MD 21136 George H. Burnham Sr. 20b. Plece of Disposition (Name of cempetery, cremetory or other plece)
Garrison Forest V.A. Cem. 6/21/00 Owings Mills, MD 20e. Method of Disposition 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) 22. Name and Address of Fecility 11824 Reisterstown Road 21. Signature of Funeral Service Licenses line 7222 ELINE FUNERAL HOME Reisterstown, MD 21136 Approximete Interval Between Onset end Death 23a Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line. **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical Undiac Examiner Physician/Medical Examiner sician and burlei-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence ol) P.O. Box 68760. Due to (or es a consequence of) for use es tha Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be dated 1 Yes 2 No 3 Probably 4 donknown Records, à Completed 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an eutopsy performed? 1 🗌 Yes 2 3 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai or Attending Physician: B 25. Wes case reterred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral c 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending To the Hospital or Attending within 24 hours effect death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, larm, street, lectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner as stated. (Check only one) er: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stelled. 29b. Signeture and little of 29c. License number 29d. Dale signed (Month, Day, Year) D27569 30. Name and address of person who com death (Item 23a) (Type, Print) 1838 Greene Tree Rd #300 len ith, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

JUN 1 9 ZUUU

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 00 liam /Medical 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner H Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Hospita ente Harbon if Under 1 Year 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys Months igM 2□ F Yrs. 77 Director Usual Residence of Decedent the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified an angle. 1 ☐ Yes 2 ☐ No Funeral Director Buch 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 HARVARO Koac United Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Giva 14. Race - Amarican Indian, 11. Marital Status Black, Whita, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify if Yes, Giva Year or Dates: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) art 18. Mother's Name (First, Middle, Meiden Sumame) 1Z. Fathar's Name (First, Middla, Last, Be lizabeth Iristopher COMO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Elizabeth Moldenhauer Mother 14 Harvard Road Glen Burnie, Maryland 21060 20b. Placa of Disposition (Name of cemeter, crametory or other place) Chesapeake Cremation Center, LLC 20a. Method of Disposition Data 20c. Location - City or Town, State June 19, 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State 2000 4 □ Donation 5 □ Other (Specify) Stevensville, Maryland ature of Fuheral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue, S.W. Second Avenue, Glen Burnie, Maryland 1100 Z64 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List onlylone ceuse on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Ver remajur Examiner Due to (or as a consequenca of): The law requires that the death certificate be executed the burial-trensit Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Diseese or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): use as signed by the at Id be deteched for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate al or Attending Physician: T s after death. In Director: After this certificat ed in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) filled in by 4 T Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. edicai completely

State Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Pay, Year)
JUN 1 9 2000

(Check only one)

29b. Signature and title of certifier

young

32 Registrar's Signature

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and

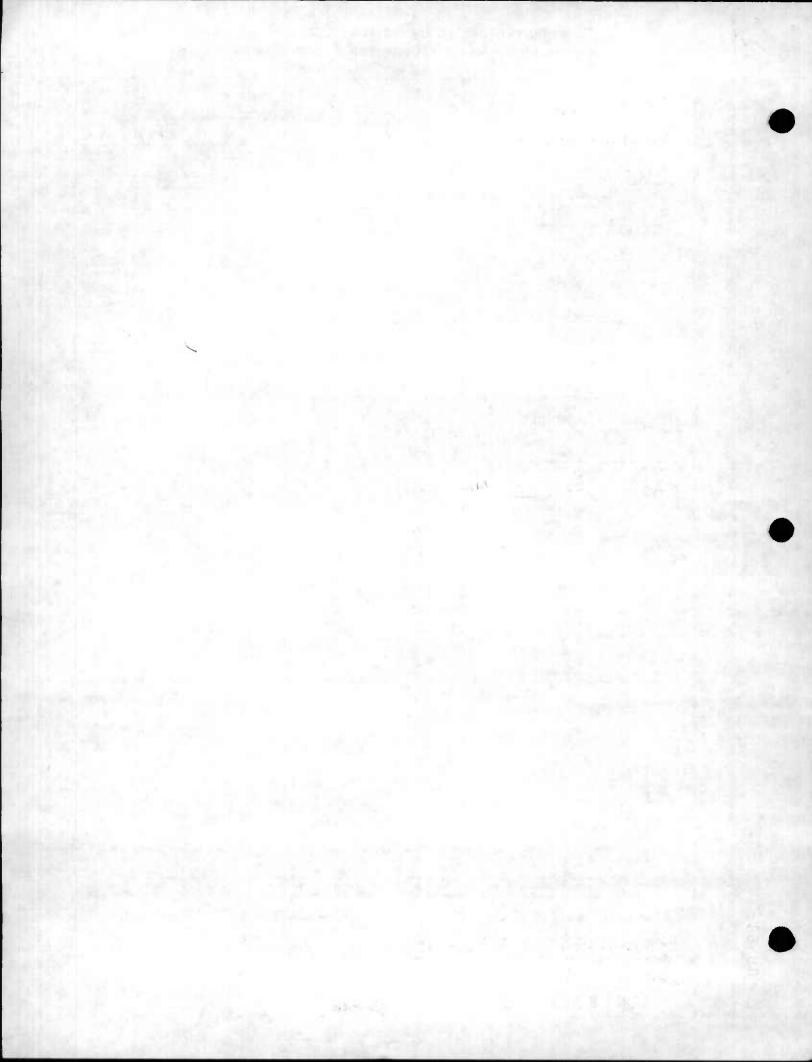
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

2000



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Fred Fallik 10:02 p.m. June 16, 2000 4b. City, Town, or Location of Dealh 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth 9720 Basket Ring Road Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Jan. 5, 1946 9. Birthplece (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthdey) XDM 2DF 54 Yrs. 094-36-0928 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9720 Basket Ring Road 21045 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 X Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes XXNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 12 College (1-4or 5+) Psychologist US Customs Service 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Solomon Fallik Anne Ruskin 19a. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Lynn Fallik/Wife 9720 Basket Ring Road, Columbia, Maryland 21045 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Columbia Memorial Park 6/19/00 Clarksville, MD 22. Neme end Address of Fecility Witzke Funeral Homes, Inc. WU1142 5555 Twin Knolls Road, Columbia, Maryland 21045 , or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, List only one ceuse on each line. Pancreatic Iskt Cell Cancer to the Liver Immediete Ceuse (Final disease or condition resulting in deeth) Due to (or es a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying

**Physician** /Medical Examiner

ettanding physician end for use as the burial-transit

signed by t. d be detach

pege 2 should

this funaral

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

or Attending Physician: The lew requires that the death certificate be assecuted

Division of Vital Records, P.O. Box 68760.

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

MD

**Funeral** 

Director

with the Maryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or frems 23a or 28a-f show shi fujury or other traumatic event, the Maddel Examinet must be notified at ence.

Baltimore, Maryland 21215-0020

Examiner edical Certification: To Be Completed by Physician/Medical

24e. Wes an eutopsy performed?  24b. Were autopsy final aveileble prior to completion of certification of ce	Cause (Disease or injury that initieted events resulting in death) Lest	c	or es e consequence of)						
25. Wes case referred to medical exeminer?  1   Yes   2   No   No   Yes   No   Yes   Y	Part II. Other significant conditions	contributing to death but not rea	sulting in the underlying	ceuse given in Pert I.					
25. Wes case referred to medical exeminer? 1   Yes   2   No			SWAR (S			24b. Were autopsy findings aveilable prior to completion of cause of death?			
exeminer?    Was 2 No					1□ Yes 2 No	1 Yes 2 No			
The spite of the s					eath (Check only one)				
1 Maturai 5 Pending (Month, Dey Year) Injury Work? 2 Accident investigetion 3 Suicide 6 Could not be determined determined	1 Yes 2 No	Hospitei:	☐ ER/Outpatient 3☐ D	OA Other: 4 Nursing	Home 5 Residence 6 □Oti	her (Specify)			
determined 286. Piece of Injury - At nome, farm, street, factory, office	1 ☑Natural 5 ☐ Pending	(Month, Dey Year)	rred						
	datamina	288. Piece of Injury - At n		28f. Location (Street and Number or Rurel Route Number, City or Town, State)					
29e, Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.  2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.	(Check only 2 Medical Exa	miner: On the besis of examine							

D38509

June 19 2000

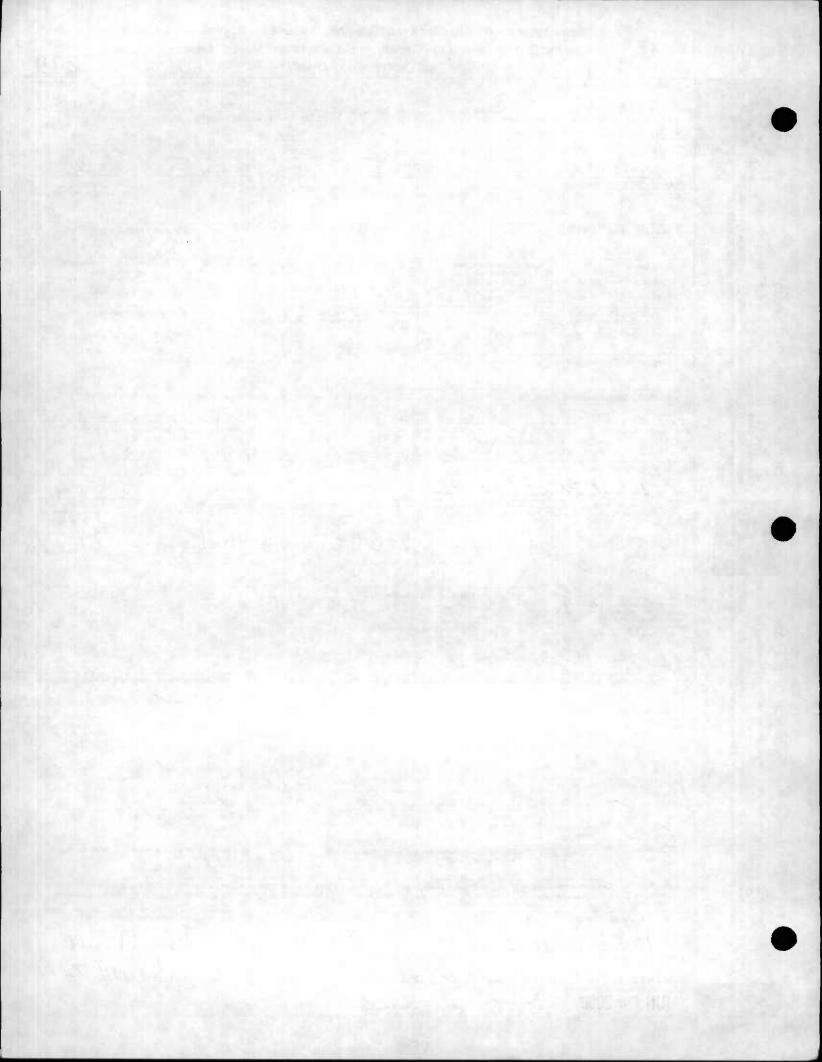
State Registrar

KOLVASIM

31. Date filed (Month, Day, Year)
JUN 1 9 2000

**DHMH 16 Rev 6/95** 

death (Item 23a) (Type, Print)



ANCIS RD JR.	AMEND ITEMS: #23		27 1 EK 1	" Cen	titicate of	Death			00 19280			
Physician	1. Decedent's Neme (First, Middle FRANCIS GRAYS)		D				2. Dete of De Month	Dey	Yeer 3. Time of Deeth			
/Medical	4a Facility Name (If not in stitution					4b. City, Town, or	JUNE Location of Dee	14,200 th 4c. County				
Examiner	1800 E.MADISON					BALTIM	ORE	N	I/A			
Funeral Director	5. Sociel Security Number 212-78-1927		7. Age (In yrs. I 42	last birthdey) Yrs.	If Under 1 Year Months Days	If Undar 24 Hrs	8. Dete of B	irth	Birthplece (Stele or Foreign Country)     MD			
	Usuel Residence of Decedent											
28a-f show notthed at rector	MD Harfor	rd		, Town or Loc .ston	ation				10d. inside City Limits 1 ☐ Yes 2 🖾 No			
or 28 S not	10e. Streel and Number			10g. Citizen of V	Whet Country?							
23e or ust be ral Dir	3208 Ascot Lane		12		21047			USA				
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la mark raumati T	19e. Informent's Neme/Reletions			19b. Meiling	g Address (Stree	t end Number or R			Stete, Zip Code)			
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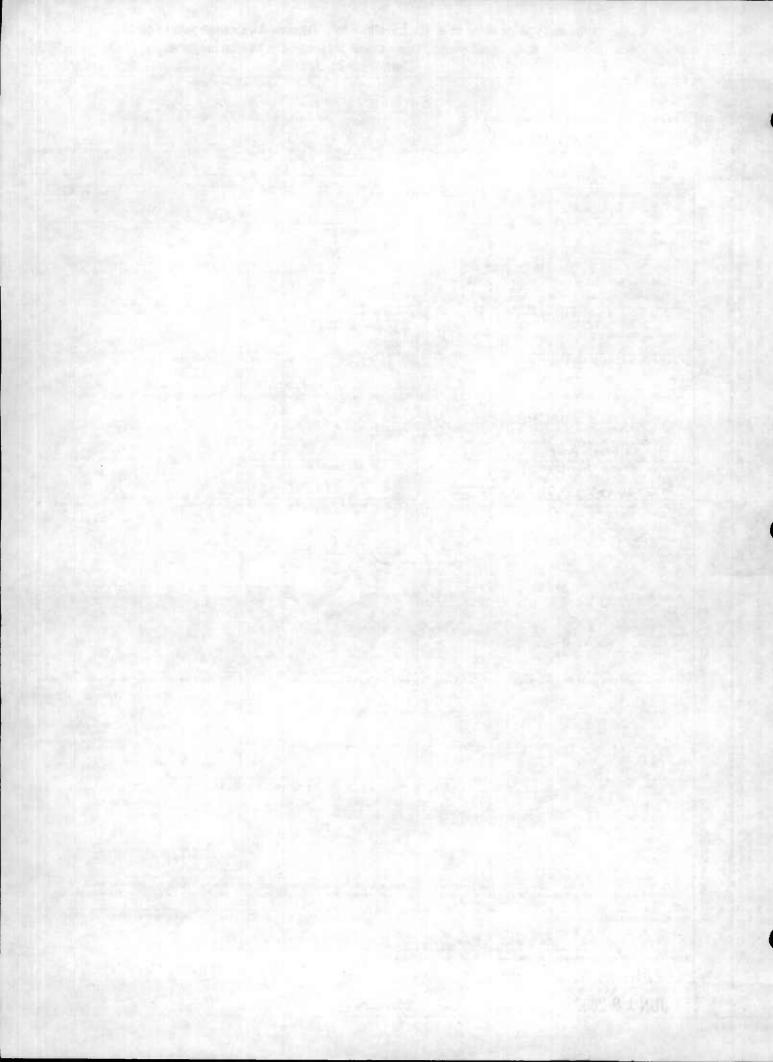
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Stronen S, Radentz, M. Q 31. Deteriled (Month, Dey, Year)

JUN 1.9 2000

Service Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Day 15 Elizabeth Ann Fallon 4:25 PM June 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 X F 157-34-8908 Yrs August 1 1940 New Jersey Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Baltimore Maryland Baltimore 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21239 6907 E. Lachlan Circle United States 12. Was Decedent Ever In U,S Armed Forces? 1 ☐ Yes 2 ŽÌ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Horace Lord Lansing Elsie VanDenberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2520 Riverbend Road Allentown, PA 18103 Tim Fallon (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 📉 Removal from State 6/19/00 4 ☐ Donation 5 ☐ Other (Specify) Maple Grove Cemetery Islesboro, Maine 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Steven T. Bittle Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 Approximete tnterval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each tine. fmmediate Cause (Final disease or condition resulting in death) Cardio-Pulmonary Failure Due to (or as a consequence of) Chronic Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) C.O.P.D. Due to (or as a consequenca of) 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide

The law requires that the death certificate be executed ettending physician and for use es the bunel-tran Division of Vital Records, P.O. Box 68760. signed by the e been si has a 2 r this certificeta has aral director, paga 2 After this funeral of death.

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Š

Completed

**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Haalth and Maniel Hygiane. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Express. That is notified at 905s.

**Physician** 

/Medicai

Examiner

laltimore, Maryland 21215-0020

Physician/Medical þ Completed Be 9 Certification:

edical

Examiner

or Attending Physician: Director: / • Funeral Di letaly filled in Hospital pietaly within 2 To the

Q

Registrar

31. Date filed (Month, Day, Year) JUN 1 9 2000

4 Homtelde

(Check only one)

29b. Signature and fittle of certifier

29a. Certifier

Charles F. O'Donnell, M.D. 111 Hamlet Hill Road Baltimore, Maryland 21210 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 09383

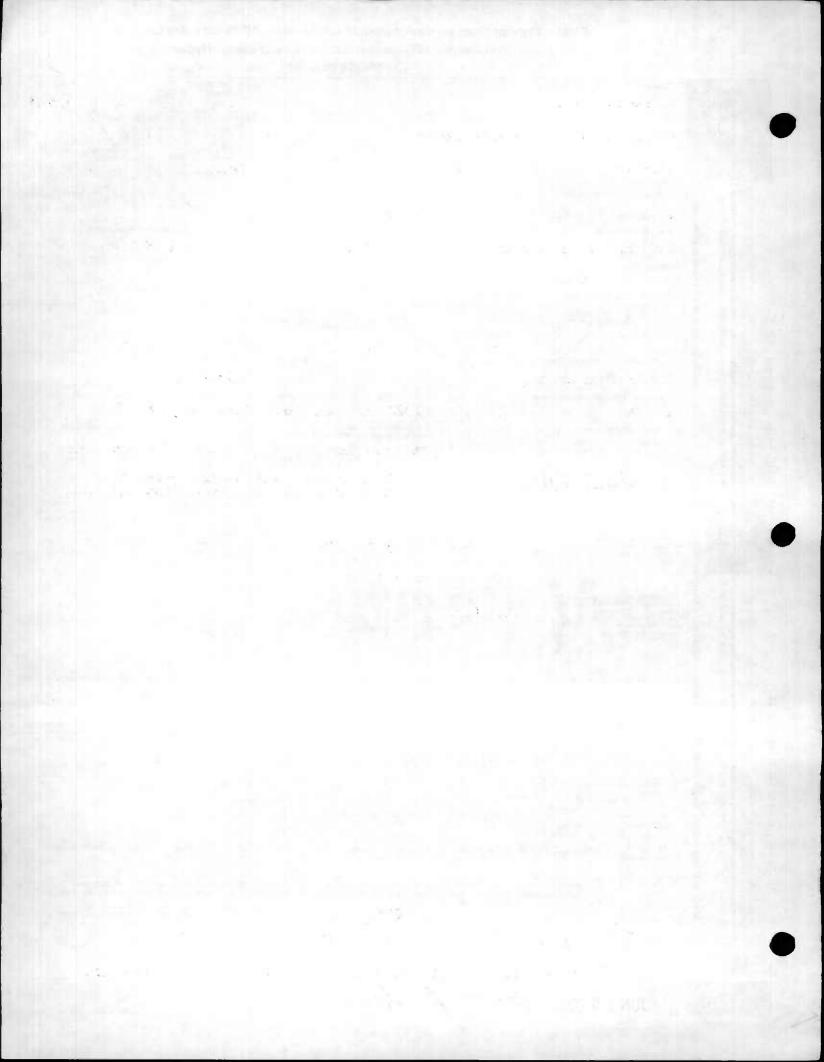
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

June 16, 2000

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

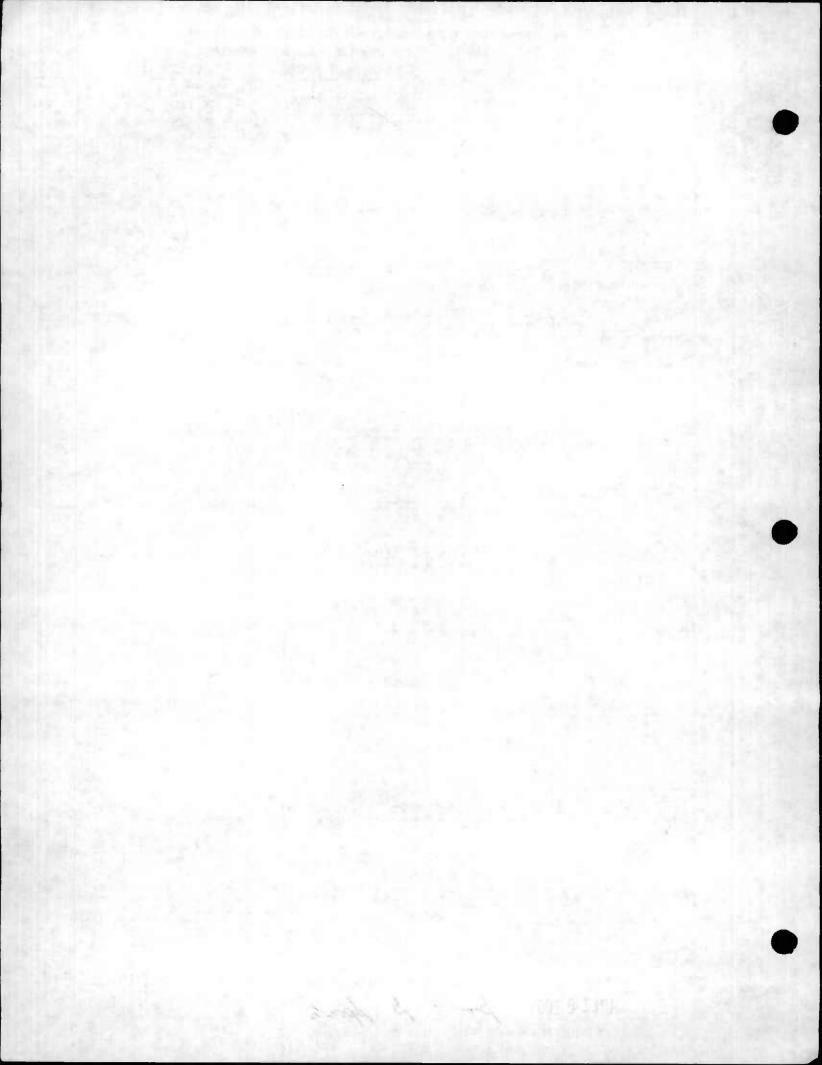
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 00-3176-510 State of Maryland / Department of Health and Mental Hygiene PART I, 27, 284-Fig PER of Death 786 9-6-00 WR. Reg. No. 9283 UNK-00-147 AMEND ITEMS: #23 Antonio Goodman JVW cedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month JUNE 09 **Physician** 2000 03:49 A.M /Medical 4b. City, Town, or Location of Deeth 4e Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Baltimore 800 Block Winston Avenue If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth Months Days Hours Min. Month, Day, Ye 9. Birthplaca (State or Foraign 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months 215-94-4489 Usual Residence of Decedent 1 MM 2□ F YES. Director 10d. toslde City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 Was 2 No Director land 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3 deld Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Stetus 72 hours after 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Dates: 1 Nevar Married 2 Married 21215-0020 1 Yas 2 4No Specify: À 3 Widowed 4 Divorced Hme Icar MO Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Hygiene. ther then 14, the Mee filled within Elamentery/Secondary (0-12) College (1-4or 5+) Maryland 18. Mother's Nama (First, Middla, Majdan Sumama) 17. Father's Nama (First, Middle, Last) Be ould be ! Pages 1 and 2 should 2 19a. Informant's Name/Reletionship (Type, Print) (aunt 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) altimore, 20b. Place of Disposition (Nama of camatary, cramatory or other placa) 20e. Mathod of Disposition /Date 20c. Location - City or Town, State Department of himportant, if its any injury or of 1 ⊠ Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signatura of Funerel Sarvice Lie 22. Nama and Addrass of Facility Joseph Ave. WiNorth Approximata Interval Between Onsat and Death sa, or complications that caused the death Do not antar tha moda of dying, such as cardiac or raspiratory arrast, Physician GUNSHOT WOUND OF HEAD /Medical Immedieta Causa (Final disaase or condition rasulting in deeth) Examiner Dua to (or as a consequanca of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata causa. Enter Undarfying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or es e consequença of): Box 68760. Physician/Medical Due to (or es a consequança of): 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Records, by 500 24b. Were autopsy findings evailabla prior to completion of causa of death? Completed 24a. Was an autopsy performed? Yes 2 No of Vital 25. Was case rafarred to medical examinar? edical Certification: To Be 26. Placa of Daath (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Residence 6 Dothar (Specify) Scene 1 Ves 2 No this funeral 28a. Data of Injury (Month, Day Year) 6-9-00 28b. Tima of A 28c. Injury at Work? 27. Mannar of Death 28d. Dascribe how injury occurred Division or Attending 1 Natural 5 Pending s after death.

I Director: Aft
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2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies. completely 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) June 09, 2000 O. C. M. E. 30. Nema and addrass of person who completed cause of deeth (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Laron Locke M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 1 9 2000

DHMH 16 Rev 6/95

Carried BURN No. 2 All Carried Burns and Carried

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Registrar

Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Yaar **Physician** 0820 Catherine Ann Giardina 2000 June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** Baltimore n/a St. Agnes Mospital Goocaton Avenue 7. Aga (In yrs. last birthday) If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day Year) | Dec. 15, 1933 9. Birthplaca (Stata or Foreign Country)
Maryland 5. Social Security Number **Funeral** 1□M 2₽F 213-32-7256 Director Usual Rasidanca of Decedant with the Maryland 10c. City, Town or Location 10d. Insida City Limits 10a. Stata 10b. County 7 is marked other than "natural", or froms 23s or 25s-4 show traumatic avent, the Medical Examinar must be notified at 1X Yas 2 No Maryland n/a Baltimore Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 3939 Roland Avenue #402 21211 U.S.A. death v Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 0 No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 72 hours after 1 Nevar Married Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usuat Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Hygiene. Elamentary/Secondary (0-12) 12 yrs. Collega (1-4or 5+) Home Maker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths, any injury or other traumatic avant, DRCB. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be John Frey Norma 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Miss Theresa G. Giardina/Daughter 108 Jumpers Circle Baltimcre,Maryland 21236 20b. Placa of Disposition (Nama of cematary, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1) Burial 2 Cramation 3 Ramoval from Stata Loudon Park Cemetery 6/19/2000 Baltimore, Mayland 4 □ Donation 5 □ Othar (Specify 21. Signatura of Funding Service 22. Nama and Addrass of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimcre, Md. 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Daath **Physician** Bacterial Sepsis /Medical Immediata Causa (Final disaasa or conditio rasulting in death) Examiner atherine A. Giardina Examiner astric Cancer ears hysician and the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disaasa or Injury that initiated avents rasulting In daath) Last Dua to (or as a consequence of) Physician/Medicai Dua to (or as a consequence of): usa 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NAME Division of Vital Records, P.O. Mellitus 3 Probably 4 Unknown 1 Yes 2 No ģ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performad? complation of causa of daath? 1□ Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Chack only ona) Hospital: 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 10 27. Mannar of Death 28b. Tima of Injury 28a. Data of Injury (Month, Day Year) 28d. Dascriba how Injury occurred edical Certification: 28c. Injury at Work? Hospital or Attanding 24 hours after death. 5 Pending invastigation Natural after death. 1 Yas 2 No 2 Accidant 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicida 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 ☐ Homicida To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifier (Check only one) 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifian 29c. Licansa number June 16, Con 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) V Told Rau 900 caton Avenue, Baltimore Maryland 21229 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JUN 1 9 2000 Registrar

**ORIGINAL** 

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9286 AMEND#20C PER F.H.&26 PER MD. G784 6-19-00JAB Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** June 9, 2000 5:58 PM ELSIE MARIE HOSEK GRIGG /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner City Baltimore Good Samaritan Hospital 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) **Funeral** Days Hours Months 1□M 2\ F Yrs. 98 Director 220-50-3941 Nov 14, 1901 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Baltimore City 28a-1 N/A 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code b 21212 238 109 Enfield Road USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: à 3 NWidowed 4 □ Divorced White Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8th Own Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) of Health and Mental H I Hem 27 is marked off r other traumatic even 89 Mary 2 Koska Joseph Hosek 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21042 19e. Informant's Name/Retationship (Type, Print) 9050 A Frederick Road, Ellicott City, Maryland Preston A. Pairo, III, Esq 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stele 20a. Method of Disposition Department of himportant: If its any injury or of 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removat from State PIKESVILLE, 6/14/2000 4 ☐ Donation 5 ☐ Other (Specify) <u>Druid Ridge Cemetery</u> Maryland 21. Signature of Funeral Service 22. Name and Address of Facility ausm Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson

6500 York Road, Baltimore, Maryland 21212

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest,

Approximately a such as cerdiac or respiretory errest,

Approximately a such as cerdiac or respiretory errest, Approximate Intervet Between Onset end Death Physician ARDIOVASCULAR DIGASE /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): physician s the buria Box 68760. Physician/Medical Due to (or as a consequence of): 950 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, à P P 24b. Were autopsy findings evaileble prior to completion of cause of deeth? 24e. Was an eutopsy performed? Completed page 2 certificate has 1 ☐ Yes 2 ☐ NO 1 🗆 Yes 2□ No of Vital Physician: 25. Was cese referred to med examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nosidence Hospital: edical Certification: To 1 Yes 2 1 ☐ Inpatient 2 ☐ FR/Outpatient 3 ☐ DOA 6 Other (Specify) After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Division Attending 1 | Netural 5 Pending investigation after death. 1 Yes 2 No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 5 To the Hospital
within 24 hours a
To the Funerel C Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner at a date. 29a. Certifier (Check only one) 29b. Signature and title of certifing 29c. License number 2000 ERIC, PISHER 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) MO 2360 West Rville 31. Dele filed (Month, Day, Year)
JUN 1 9 2000

DHMH 16 Rev 6/95

State Registrar

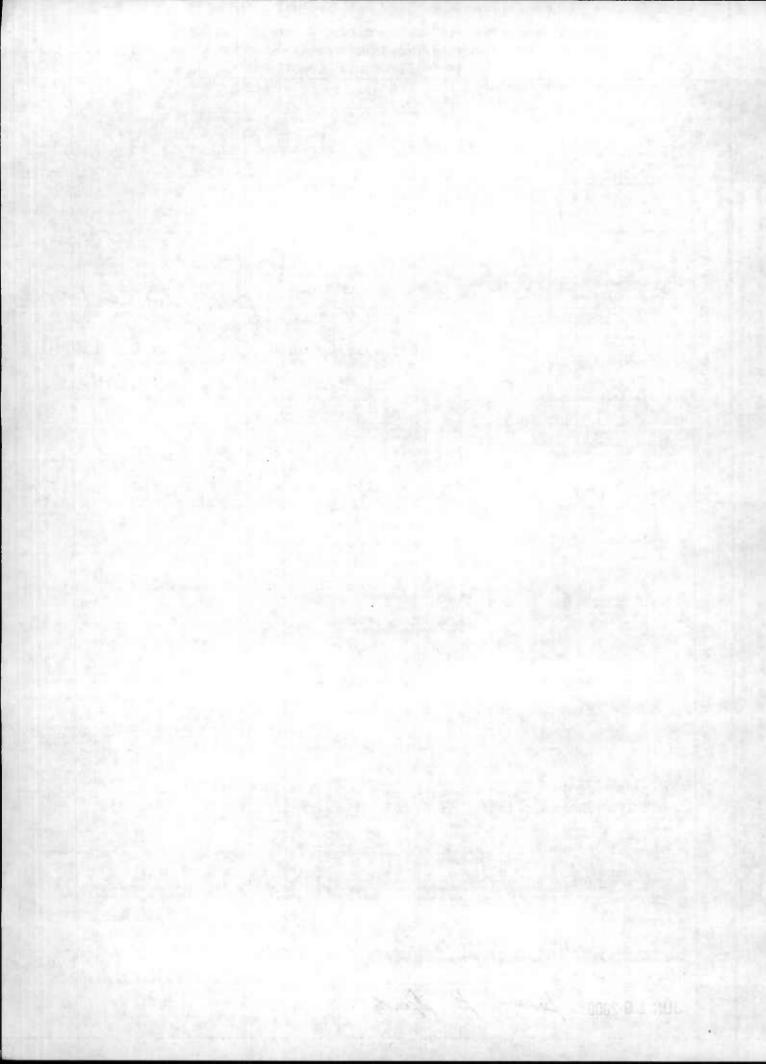
#### Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 287 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 23 Pm 6 00 /Medical Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Dout Examiner mor If Under 24 Hrs. 8. Date of Birth Hours Min. (Month Day If Undar Months 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Days 1□ M 2Q F Director rainia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 Xes 2 No laryland Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with or items 23a or a12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11 Marital Status Black White etc. 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates: 2 Married 2 No Baltimore, Maryland 21215-0020 1 Yes 200 No Specify Completed by 3 ☐ Widowed 4 ☑ Divorced an natural 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 0 Vor rivate 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be innent of Health and Mental and: If frem 27 is marked o 0 traumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (son Department of Health a important: If them 27 le any injury or other tra ea 10 Hua 20b. Place of Disposition (Neme of 20c. Location - City or Town, State Date 20a. Method of Disposition metery, crematory or other place) 1 Burlal 2 Cremation 3 Removal from State 2000 Mem. Kar 4 Donation 5 □ Other (Specify) 21. Signature of Funerat Service Licenses 22 Name and Addrass of Facility 2222 enter the Willorth AUR 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final P51 disaase or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner ARRES ARBIAC The law requires that the death certificate be executed attending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? paga 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of death? After this certificata has 2 No 1 Yes 1 ☐ Yes 2 ☐ 110 Physician: eral Director: After this certific filled in by the funeral director, 25. Wes case referred to medical axaminar? edical Certification: To Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1. Naturat 5 Pending Invastigation 1 ☐ Yes 2 No death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of tnjury - Al home, farm, street, factory, office building, etc. (Specify) after 4 Homleide To the Hospital o within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signsture and title of certifier 0 00 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) TIMORE BAZEE SECOURS HOSPITAL DAAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Vaar **Physician** 0642 4a Facility Name (If not institution give street end number) 2000 UNE /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE THE JOHNS HOPKINS HOSPITAL octal Security Number 6. Sax 7. Aga (In yrs. lest birthday) If Undar 1 Yaar If Undar 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) 05-19-56 Birthplaca (State or Foreign Country) **Funeral** 10 M XXF 44 Yrs. Director 220-64-0960 **Usual Rasidence of Decedent** the Maryland 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Example; must be notified at 1€ Yes 2□ No Funeral Director MD NA Baltimore 10f. Zin Code 10g. Citizan of What Country? 10e. Street and Number 21213 USA 1116 N. Milton Avenue 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, apecify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer to Depertment of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or heavy injury or other traumatic events. 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: Black Completed by 3 ₩ Widowed 4 Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Day Care Provider 12th Grade 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be ( Goodes Scrivens Sarah Alglenn 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 19a. Informant's Neme/Reletionship (Type, Print) 1116 N. Milton Avenue baltimore, Maryland Sarah Goodes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 20a. Mathod of Disposition 1 ₺ Burlal 2 Cramation 3 Ramoval from Stata Voshell Mem. Gardens 06-22-2000 Dundalk, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Baltimore, Maryland 21202 21. Signature of Funaral Service Licensee WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Intarval Between Onset and Deeth **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting In death) Examiner Dua to (or as a consequence of): Examiner iocqulopath attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Box 68760. Secre Physician/Medical Dua to (or as a consequence of): P.0. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, þ 8 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy parlormed? Medical Certification: To Be Completed page 2 After this certificate hes 1 Yas 2 THE 1 ☐ Yas Physicien: director, 25. Was casa rafarred to medical 26. Placa of Daath (Check only one) exeminar? Hospitel: 1 patient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2546 spital or Attending Physical after death.

neral Director: After this y filled in by the funeral di 27. Menner of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Naturel 2 Accident 5 Panding invastigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be detarmined 3 ☐ Sulcida Location (Street end Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier completely (Check only one) 29c. Licensa number 29d. Data signad (Month, Day, Year) 29b. Signatura and title a certific -000 2000 nd addrass of person who completed causa of death (Itam 23a) (Type, Print) JOHNS HOACHS HOSATAL SED 1200m 110 NER 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

**DHMH 16 Rev 6/95** 

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9289 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month 8:00 PM C. Stanley June 14, 2000 Hansen, 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Union Memorial Hospital Baltimore If Under 24 Hrs. Hours Min. If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1 M 20 F 52 213-52-5704 Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits YYes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3354 Chestnut Avenue 21211 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 □ No If <del>Yes</del>, Give Year or Dates: 1967-69 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Self Employed Elementary/Secondary (0-12) College (1-4or 5+) Convienence Store Operator 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Waldo Hansen Taylor Pauline 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 3354 Chestnut Avenue, Georgeanna Hansen 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremetion 3 Removal from Stete 4 Donetion 5 Other (Specify) Maryland Veterans' Cemetery 19 Garrison Forest, MD 21. Signature of Funeral Service Lin 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIORESPIRATORY ARREST Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of): 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

Examiner

Physician/Medicai

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Certification: To

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altimore, Maryland 21215-0020

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Pages 1 and 2 should be nent of Health and Mental

epartment of

**Physician** 

/Medical

Examiner

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**Funeral** 

Director

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No 28b. Time of Injury 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basia of examination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

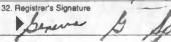
29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

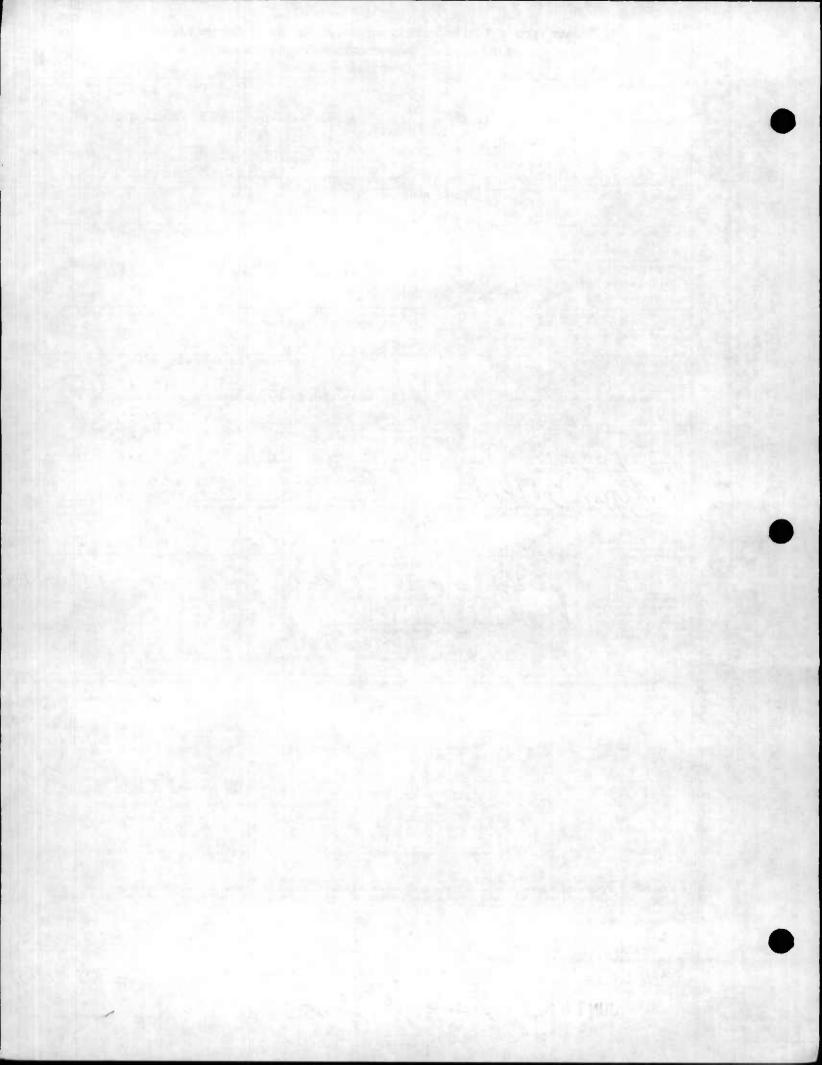
SOTIRESC 10 N GREENE ST, BALTIMORE, MD 21201 VA BALTIMORE 31. Date filed (Month, Day, Year)

State Registrar

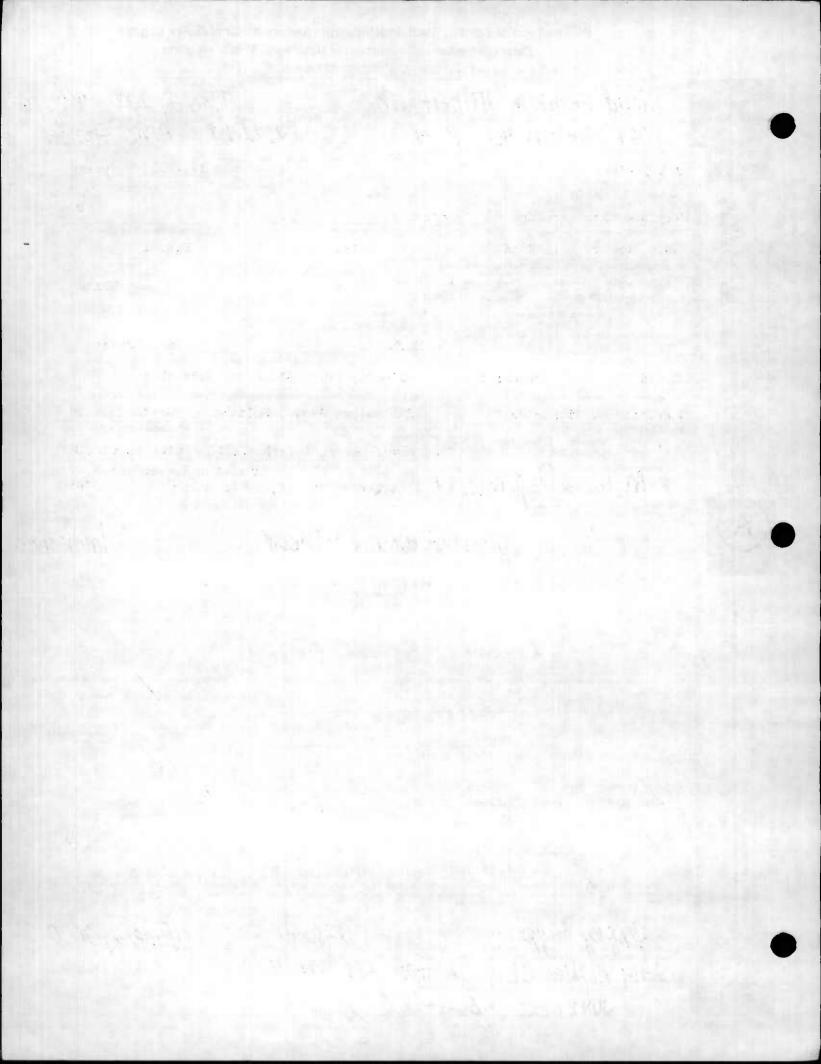
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**ORIGINAL** 



E	AMEND IT	EMS: #28A-F PER MEG	State of Maryland				giene	19290		
	Physician · /Medical	1. Decedent's Neme (First, Middle, La.	Kin Hilber	t Ir.		2. Date of Dea		3. Tima of Death 7:00 pm		
-	Examiner  Funeral  Director	4e Facility Name (If not institution, given 19029 Tump of 5. Sociel Security Number 1903 1904 1905 1905 1905 1905 1905 1905 1905 1905	ers Hole Roa	(1) If Under 1 Ye Months Day		denq 8. Date of Birt	h Anne	Deeth Arundel 9. Birthpleca (State or Foreign Country) (aryland		
Adend		Usuel Residence of Decedent  10a. State 10b. County	10c. City,	, Town or Location				10d. Inside City Limits		
1	t or 28s-f s be notified Director	Maryland Anne Aru	ndel Pasa					1X Yes 2 No		
1	I Dir	10e. Street and Number 8029 Jumpers Hole	Road	10f. Zip Code 21122	θ		10g. Citizen of Wh	nat Country?		
020	ed within 72 hours after death with the Maryla ygjene. writhen "naturel", or liems 23s or 28e-f show it, the Medical Examiner must be notified at Completed by Funeral Director	11. Marital Stetus  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U,S Armed Forces? 1⊠ Yes 2□ No 195 if Yes, Give Year or Datas: 195	3- 13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Stuben, Mexican, Puer No Specify:	specify Yes or No- to Rican, atc.)	14. Race	American Indian, White, etc. White		
Maryland 21215-0020		15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	16e. Decedent's Usuel Oc (Give kind of work do life. DO NOT use ref	cupation ne during most of wo lired)	rking	16b. Kind of Busi			
pu	d other event, 1	17. Father's Name (First, Middle, Last)			18. Mother's Ne	me (First, Middle,	Maiden Surname,	*		
yla	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Lloyd	Franklin	Hilbert, Si			reiber			
Mary	마르 프	19e. Informent's Name/Relationship (19) Charlotte L. Ticha		19b. Mailing Address (Str. 1345 Walker						
ore,	of Heal	20a. Method of Disposition	20b. Pie	ece of Disposition (Name of matery, cremetory or other)		Date		ity or Town, State		
Baltimore,	ment in ment in ment in ment in in in in in in in in in in in in in	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from Stete	n Haven Memor	rial Park			rnie, MD		
Ball		21. Signature of Funeral Servica Licen	anh MO1234		Ave, S.W.					
1.	hytician /Medical :xammer	23a. Part1. Enter the disease, or com shock, or heert tailure. List only Immediate Cause (Final disaasa or condition resulting in deeth)	a. gunshot	es a consequenca of):	n head	c or respiratory er	rest,	Approximata interval Between Onset and Death		
Box 68760,	attending physician and for use as the burial-transit clan/Medical Examiner	Ceuse (Disease or Injury that initiated events Due to (or as e consequenca of):								
P.O.	ed by the atte detached for y Physicia	Part II. Other significant conditions or	ontributing to death but not rasul		23b. Did tobacco usa sontribute to the cause of					
Records,	Pis b					24e. Wes	en autopsy med?	24b. Were eutopsy findings evailable prior to completion of cause of deeth?		
- F	certificate ha	05.111				101		1 ☐ Yes 2 ☐ No		
of Vital	is certific director.	25. Wes case referred to medical examiner?  1 12 Yes 2 No	Hospital: 1 ☐ Inpatiant 2 ☐ E	ER/Outpatient 3□ DOA	Other:	ath (Check only of		(Specify)		
Division	iffer death.  Nivector: After in by the fune	27. Manner of Deeth  1 Neturel 5 Pending investigation  3 12 Suicide 6 Could not be determined	28a. Dete of Injury (Month, Day Year)  JUNE 2, 2000  28e. Place of Injury - At hor building, etc. (Specify)	28a. Dete of Injury at Work?  JUNE 2, 2000 7:00 M  28e. Place of Injury - At home, farm, street, fectory, office building, efc. (Specify)			4 Industry Home 3 to Residence 6 Liother (Specify)			
John House	n 24 hour	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of my know hiner: On the basis of exemination	rledge, deeth occurred at the on end/or investigation, in m	e time, date and plece ny opinion, deeth occ	e, end due to the	ceuse(s) end men	ner es stated.		
	within and within a To the Funeral Completely filled	29b. Signature and title of cartifier	My My	Di	ense number 38640		29d. Date signed	(Month, Day, Year)		
	State Registrar	31. Date filed (Month, Day Year)	completed cause of deeth (Item 32. Registrar's Signate	ton Ma	2114					
	riegistiai	JUNI 7	2000 Sener	In the	acks.					



Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** 15 2:45AM June 2000 Hartopoulos Olga /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Manor Care Towson Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 2 190 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2₽ F Yrs. 110-30-6132 Feb. 1903 Director Greece 97 Usuel Rasidence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No Baltimore Glen Arm Directo Md. 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code ò HSA 230 12811 Ponderosa Ln. 21057 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Merital Stetus Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to be permitted to the state of the permitted of 1 Never Merried 2 Merried 1 ☐ Yes 2 ☒ No If Yas, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Evangelia Varvouti George Dikos 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12811 Ponderosa Ln. Glen Arm, Md. 21057 Tasos Valanos/Son In Law 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 6-19-00 Locust Valley Cemetery Locust Valley Cemetery 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease or complications that obused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. Dist only one cause on each line. Approximete Intarval Between Onset and Death Physician Immediate Cause (Final disaasa or condition resulting In deeth) /Medical Examiner Dua to (or as a consequence of): Physician/Medical Examiner HIFME The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest use as the bunal-tran Due to (or es a cons P.O. Box 68760, azde Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Donknown Records, þ should be 24b. Ware autopsy findings available prior to Be Completed 24a. Wes en autopsy performed? completion of cause of death? certificate 1 Yes 2 10 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: director, 25. Wes casa referred to medical examinar? 26. Place of Daeth (Check only one) Hospital: 1 ☐ Inpetient Other: Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpetient 3 DOA After this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division 5 Pending investigation Natural To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicida 29a. Certifier Medical Time catifying Physician: To the best of my knowledge, daath occurred at tha tima, data end place, end due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. (Check only one) 29b. Sign le of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 24100

State
Registrar

istrar JUN 1 9 2000

31. Date filed (Month, Dey, Year)

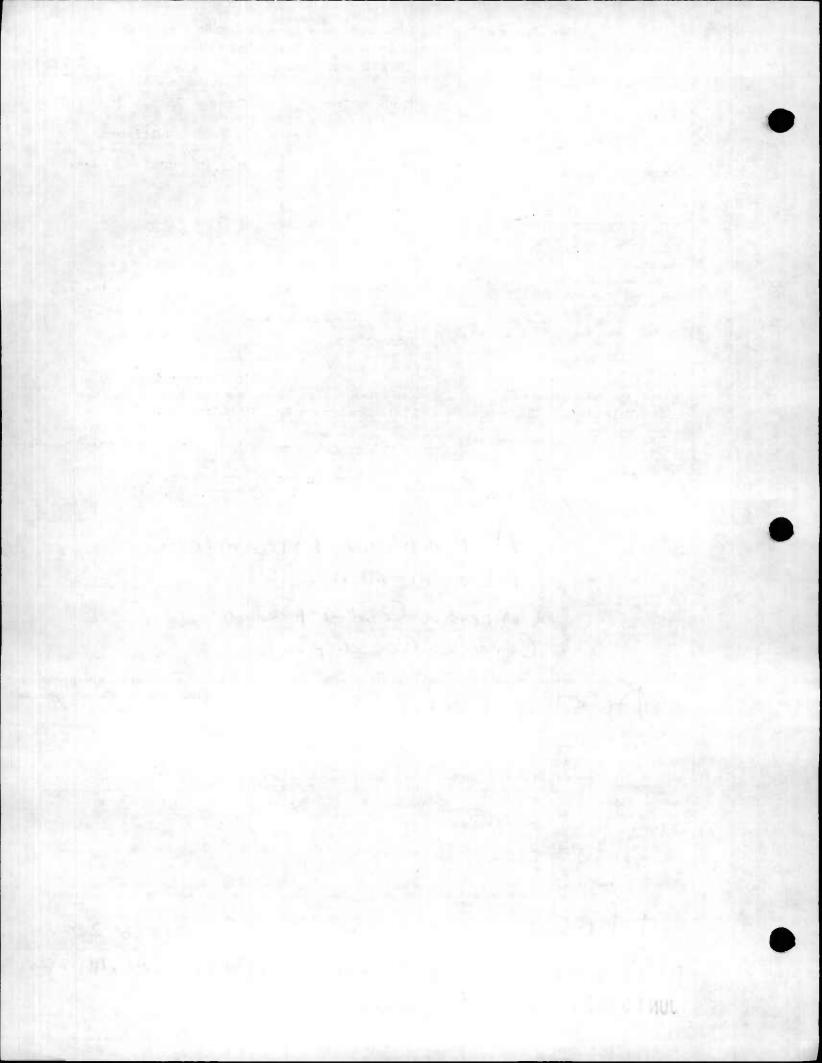
PRARHACARMO. 30, Dey, Year)

32. Registrar's Signatura

2000 Server & Spark

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

300 ARMORYPLACE BALIMDZIZO



		Decedent's Neme (First, Middle, L.	ast)		Certific	ale UI L	Jeani	2. Dete of [	Reg. No.		3. Time of the
ysicia Medica	ai	JUNE E  4e. Fecility Name (If not institution, gi	ive street end number		SLINE		h City Town	JUNE, or Location of De		Yeer 2000 Ity of Deeth	8130P
erai		6000 SAMA 5. Sociel Security Number 6.	FRITAN	4 4	birthdey) If Ur Yrs. Mont	nder 1 Year	BAL If Under 24	Hrs. 8. Date of E		9. Birthpi	
det		10a. Stete 10b. County			own or Location		<u></u>			10	od. Inside City Limit
be notifie	Directo	Maryland N/A  10e. Street end Number		Balt		. Zip Code			10g. Citizen o		•
event, the Medical Examiner must be notified at	by Funeral Director	6223 McClain Blv  11. Maritat Stetus  1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces	? No	13. Wes De	21214 ecedent of Hi specify Cuber s 2 \( \) No	spenic Origin n, Mexican, F Specify:	? (Specify Yes or I ruerto Rican, etc.)	United	eca - America leck, White, e	an tndien,
the Medical E	Completed	15. Decedent's Education (Specify only highest grede completed)  Elementery/Secondary (0-12)  College (1-4or 5+)			6e. Decedent's L (Give kind of life. DO NO	Jsuet Occups f work done d T use retired,	ation furing most of )	working	16b. Kind of Restar	Business/Ind urant	
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nanuanc nanuanc	ှ	Clarence  19e. Informent's Name/Reletionship	Hassling		Ob Molling Add	ross (Ctrasts		Elnora		un Ctata Tla	Codel
100		Monnie A. Dalton		[				Baltimor			
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- Wint Tarest

State of Maryland / Department of Health and Mental Hygiene 19293

			Ce	ertificate of	Death		Reg. No.	0	12620	
Physician	1. Decedent's Name (First, Middle, Li					2. Dete of E		Year	3. Time of Death	
Physician /Medical	ELIZABETH	GALLISON H	NOTTU			June	13, 2000		7:00AM	
Examiner	4a Fecility Name (If not institution, git					, or Location of De		y of Death		
	2204 Pine Hill		4	If Under 1 Year		ysville		Balti		
Funeral Director	015-18-3602	Sex 7. Age (In )	rrs. last birthday Yrs.	Months Days		Min. (Month, I	Day, Year) / 16,1918		place (State or Foreign ntry) achusetts	
pu k	Usual Residence of Decedent  10s. State 10b, County	10c.	City, Town or L	ocation					10d. Inside City Limits	
72 hours after death with the Maryland natural; or items 23e or 28e-1 show dies Exercises must be notified at sted by Funeral Director	Massachusetts Plymo		Duxbury						1∏Yes 2□No	
Direction of the property of t	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?	
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Tun Ita	11. Marital Status  1 Never Married 2 Married	Armed Forces?	10,3.	Wes Decedent of It Yas, specify Cut	oan, Mexican, P	verto Rican, atc.)		ck, White,		
by F	X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2/()(No	Specify:		Specia	y: W	hite	
natural,	15. Decedent's E	ducation	16a. Dece	edent's Usual Occu	pation		16b. Kind of 8	lusiness/In	dustry	
C	(Specify only highest grant   Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	e kind of work done DO NOT use retire	i during most of ad)	f working				
d withi	Librino Hary Good Gary (0-12)	2	Age	ent			Real	Estat	e	
EIAS .	17. Father's Name (First, Middle, Last				18. Mother's	Name (First, Midd	lle, Maiden Sume	me)		
	James	Galliso			Marj	orie		Kel	ls	
2 should and Men is marke summatic	19a. Informant's Name/Relationship (	(Type, Print)	19b. Mail	ling Address (Stree	t and Number o	or Rural Route Num	nber, City or Town	, State, Zij	Code 2 1030	
BELS	Edward B Hutton J	r SON	2204	Pine Hil	l Farms	Road Cod	ckevsvil	le, M	arvland	
of Haall Frem 2: r other	20a. Method of Disposition		b. Place of Disp	osition (Name of ametory or other pla		Dete	20c. Location			
	1 Burial 2 Cremetion 3 4 Donation 5 Other (Specie	JRemovet from Steta  GY		nt Cemete		6/14/00	Baltimo	re. M	arvland	
in orth	21. Signature of Funeral Service Lice			2. Nama and Addre	one of English					
o de de de de de de de de de de de de de	Duni ofha	la Mount	5.0	6500 Va		Mitchell-Wi				
	23a Part 1 Enter the disease or corr	polications that caused the d	eath Do not en			Baltimon		Tanu	Approximata	
Obveision	23a. Part1. Enter the disease, or corr shock, or heart failure. List only	one cause on each lina.				. Lacon respiratory			Intervel Between Onsat and Death	
Physician / /Medical	Immediate Cause (Finel	***************************************	NT		C 11	D 11				
Examiner	disease or condition resulting in death)			rosis of	Small	Bowel		1	Days	
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F 0	examiner?	Hospital:	□ ED/Outpatio	ent 3 DOA Ot	her _	Deeth <i>(Check</i> on <i>t</i> )	VVS	on S Ri	esidence	
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ding th.	27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury Wor 1 ☐ Accident investigation									
na attar desth. el Director: After ted in by the funer Certification:	3 ☐ Suicide 6 ☐ Could not b	289. Place of Injury - A	t homa, farm, si	treet, factory, office				ber or Rur	al Routs Number,	
din b	4 Homicide	28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)					281. Location (Street and Number or Rural Routa Number, City or Town, State)			
To the Hospital of within 24 hours at To the Funerel Di completaly illied is completaly illied in Medical Cet	29a. Certifier 1 Certifying Pt	nysician: To the best of my I	cnowledge, deal	th occurred at the ti	ime, date and p	place, and due to th	a cause(s) end m	enner as :	stated.	
he Hospi in 24 hou he Funer pletaly till edical		niner: On the basis of axam and pramer steted.								
Me Withir	29b. Signature and title of pertifier	. // .		29c. Licen	se number		29d. Date sign	ed (Mgnth,	Day, Year)	
- >- 0	D - 1/1/1	1 ( L-HA	.0	no	DEN	716 MD	111	4/61	)	
1	30. Name and eddress of person who	completed cause of death //	tem 23a) /Turns	Print)	0 3 7	JIN MY	6/1	1100		
36	Thomas W. Jarrett				timore	MD 2122	4			
State	31. Date filed (Month, Day, Year)	32. Registrar's Si	nnaAura	1		,				
Registrar	JUN 1 9 2000	Benega	D. 1	souls						

Please Type or Print in Black Indeilble Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #17 PER FH G784 6/19/2000 AH Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3 Time of Death **Physician** CHARLES HOLZMAN JUNE 14, 2000 10:40 PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOSPICE OF BALTIMORE GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 18 M 2□ F Months Days Hours Yrs. 214-26-1230 71 DEC. 1, 1928 Director MD Usuel Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits MD BALTIMORE Director BALTIMORE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? to Izman, charle 2419 FOREST GREEN ROAD 21209 U.S.A. 238 Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 (X No If Yes, Give Yaar or Detas: 13. Was Decedent of Hispanic Origin? (Specify Yes or Notit Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indien. 11. Maritel Status Bleck, White, etc. 1 ☐ Never Merried 2 X Merried b 1 Yes 2 No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) PROPRIETOR 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be and 2 should be saith and Mental OSCAR HOLZMAN OSCAR HALZMAN RAE **COOPERMAN** 19e. Informent's Neme/Retetionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) of Health of Hea MARILYN HOLZMAN / WIFE 2419 FOREST GREEN ROAD - BALTIMORE, MD 21209 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) Pages 1 20e. Mathod of Disposition 20c. Location - City or Town, Stete Department of H Important: If Its any injury or of 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 6/16/00 REISTERSTOWN, MD 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Perty. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teiture. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical VEA monta Examiner Dua to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequenca of): be execu physician s the buna 68760 Physician/Medical Due to (or es a consequence of) P.O. Box Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Records. be d þ 24b. Were autopsy findings svailable prior to completion of cause of death? Completed 24a. Wes en autopsy performed? 1 ☐ Yas 2 ☐ No Division of Vital 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After Attending 1 Neturet 5 Pending death. 1 Yes 2 No investigetion 2 Accident 24 hours after deaf Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ filled in 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated. completaly 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture end file of certifies 25205 June 13, 2000 mo

State

Registrar

**DHMH 16 Rev 6/95** 

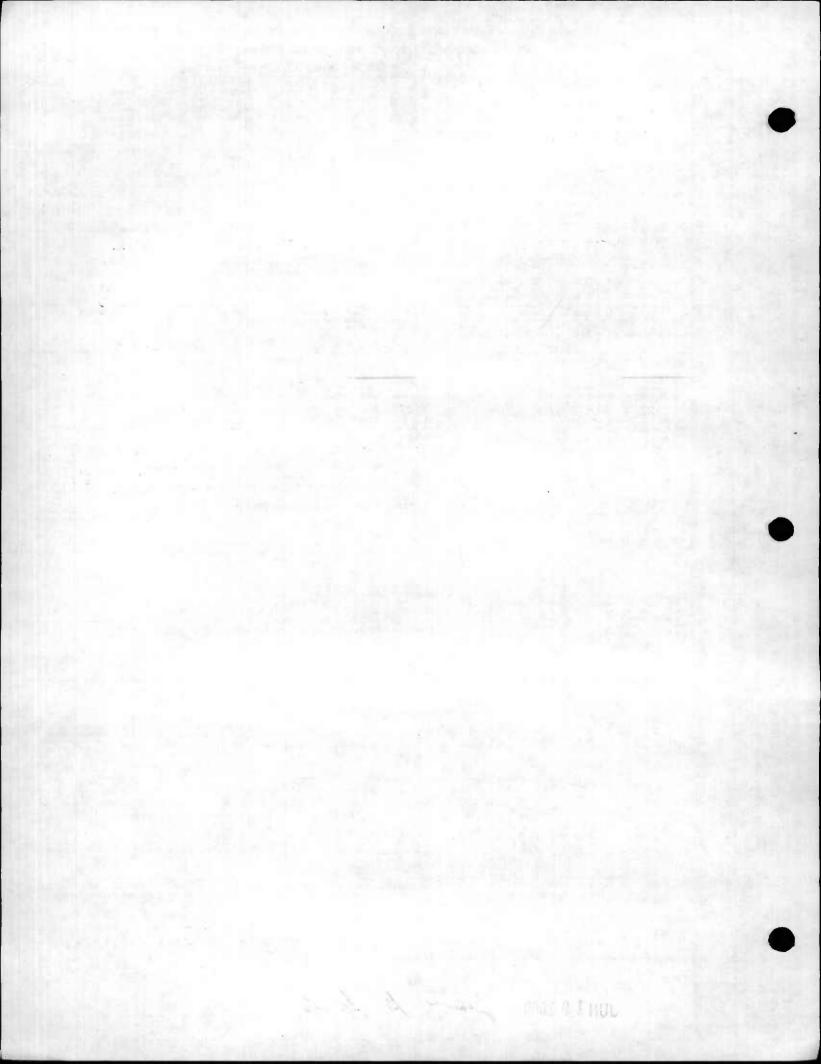
31. Dete filed (Month, Day, Year)

30. Name and address of person who completed ause of deeth (Item 21s) (Type, Print)

60

mC

1. Charles St. Balto. md 32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM: #26 PER VERBAL RESPONSE G784 6-20 TO WE and Mental Hygiene 295 AMEND ITEM: #24A PER VERBAL RESPONSE G7846-1 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month May 25, Day 2000 Year **Physician** IDA HELLER 1:58 PM \* /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner 1008 Stirling Road Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (in yrs. last birthday) 8. Dale of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1 ■ M 2 X F Vrs Director 88 Nov 17, 1911 216-44-6902 DC Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28a-f sho the Medicsi Examiner must be notified at MD Silver Spring 1 Yes 2 No Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Funeral 1008 Stirling Road 20901

13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 Never Married 2 N Married Maryland 21215-0020 1 Yes 2X No Specify: Specify: white á 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) De filed within Hygione. Elementary/Secondary (0-12) College (1-4or 5+) secretary government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental supportant if Health and Mental deportment if Health 27 is merited oil any injury or other traumment once. Be Barnett Rosenbloom 2 Bessie Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) unk 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☑ Donation 5 ☐ Othar (Specify) Ronald S. Wade Drector State Anatomy Board 655 W. Ba Baltimore, MD 21201

and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fellure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street Approximete Intarval Batween Onset and Death Physician /Medical Immediate Causa (Finai GENERALISED MONTH CARCINO MATOSIS disease or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner MONTHS ( ADVANCED) HEAD 2 NECK CANCER death certificate be executed physicien and s the burial-trans Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Causa (Diseasa or injury that initiated evants resulting in death) Last Due to (or as a consequence of): O. Box 68760 Physician/Medical Due to (or es a consequence of): 9 esn ò signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed peeu has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was casa raferred to medical examinar? Be 26. Placa of Daath (Chack only ona) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2☑ No 1 ☐ inpatient 2 ☐ EP/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of Certification: After 5 Pending Investigation 1 Natural I or Attending efter deeth. I Director: Aft 1 Yes 2 No 2 Accident 6 Could not be datermined 3 ☐ Suicida 28f. Location (Street end Number or Rural Route Numbar, City or Town, Stete) 28e. Place of injury - At homa, ferm, straat, factory, office building, etc. (Specify) filled in by 4 Homicida To the Hospital o within 24 hours of To the Funeral Di completely filled in 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number ms , mo 6/2/00 D45274 30. Name and address of parson who complated causa of death (item 23a) (Type, Print) MD 20895 10810 AVE, LONNECTICOT LENSINGTON. MAUNG

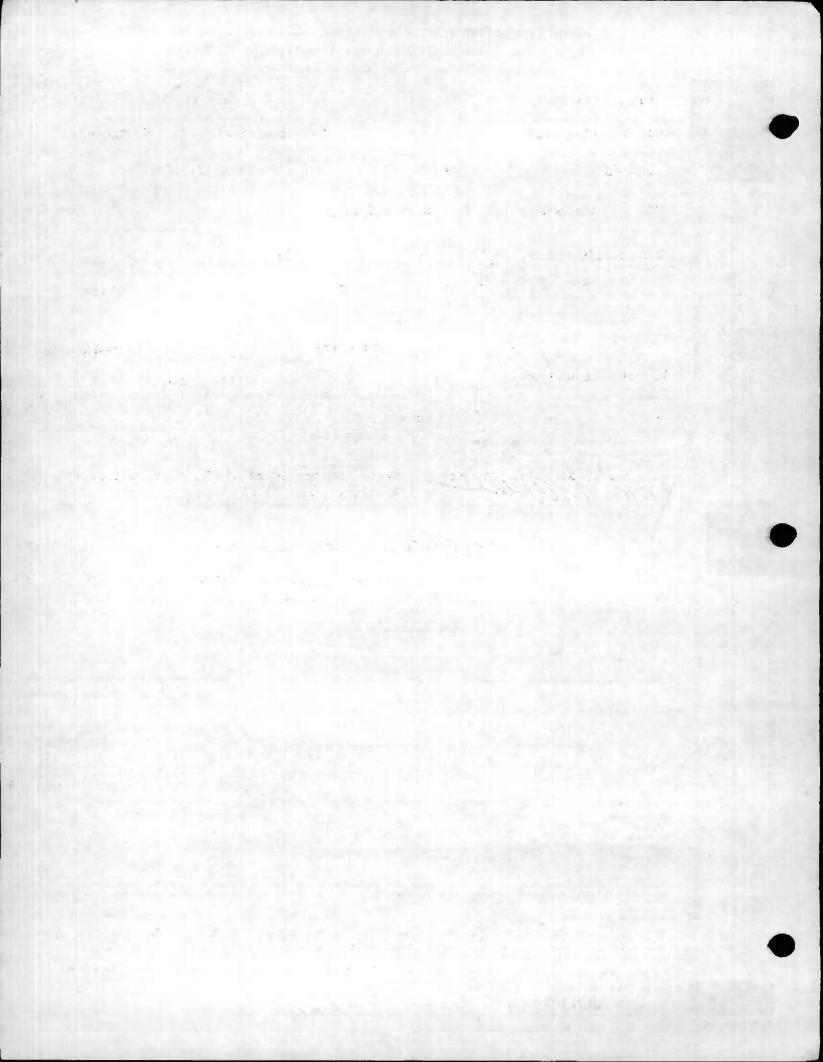
Registrar

State

31. Date filed (Month, Dey, Year)

JUN 17

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 19296

		Certificate of Death	Reg. No.	12230
Physiciar	1. Decedent's Nama (First, Middle, Last)		2. Data of Death Month Day	3. Time of Death
/Medica	VII ama L. Johns	4b. City, Town, lor Loc	June 14,200 pation of Death 4c. County of D	8 12:45 PM
Examine	6902 Bright Way Pl	aco A/A	Ba	Himore
Funeral	5. Social Security Number 6 Sex 7. Aga (In yrs. last	Months Days Hours Min	8. Data of Birth 9. (Month, Day, Year)	Birthplece (Stata or Foraign Country)
Director	Usual Rasidance of Decedent	Yrs.	May 30, 1926 14	laryland
anylend		own or Location		10d. Inside City Limits
the Mar	Maryland Baltimore	NA		1 Yas 2 □ No
offer death with the Maintener 23a or 28a-f a Maintener must be notified.	100. Street and Number Brightway P	10f. Zip Coda 1ace 21207	10g. Citizan of Whet	A
020 urs	3 Widowed 4 □ Divorced Yaar or Dates:	13. Was Decedent of Hispanic Origin? (Specifi Yas, specify Cuben, Maxican, Puarto F		marican Indian, Inita, atc. Black
72 hc	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Giva kind of work done during most of workin	16b. Kind of Busine	ess/Industry
id 21215-0 filed within 72 ho Hygiene. other than "nature ent, the Mexical	Elementary/Secondary (0-12) College (1-4or 5+)	Iffa. DO NOT usa retired)	Stato.	of Md.
and 2 the filed of other worth, the	17. Fathar's Name (First, Middla, Last)	18. Mothar's Nama	(First, Middle, Meiden Sumama)	011000
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	19a Informant's Name/Reletionship (Type, Print) (daughter)	19b. Meiling Addrass (Streat and Number or Rural	Routa Number, City or Town, Stat	ta, Zip Coda)
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Baltimore, permit. Pages 1 er Department of Hee Important: If item; eny injury or other once.	21. Signature of Funeral Sarvice Licensee	22. Nama and Addrass of Facility	Funeral Hay	MP
m gossa	Joseph L. Kuss	2-2-7- W. North A	tve Balto Md	21216
<b>TO 1</b>	23a. Part/ Entar tha disease, or complications that causad tha daath. I shook or heart faithe. List only one cause on each line.	To not antar the mode of dying, such es cardiec or	r respiratory arrast,	Approximata tntarval Batween Onset and Daath
Physician /Medical Examiner	Immediata Causa (Final disaasa or condition rasulting in death)	RDIAL INFA	4RCTION	1 MIN.
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P.O. BO) net the deeth ce d by the attend fetached for us. Dhueinian	Part II. Other significant conditions contributing to death but not resulting	g in the underlying causa given in Pert I.	23b. Did tobacco use contrib	oute to the cause of death?
P.O. that the detached by the	NYDERTENS	10 N	1 Yes 2 No 3	Probably 4 Unknown
S & & &				4b. Wara autopsy findings
The lew requirements that the second is the second in the second is the second in the	1716 N BLOOD	PILESSURE	performed?	available prior to complation of causa of death?
I Relevante has	DIABETES	IFILITIC	1□ Yas 200No	1 □ Yes 2 □ No
Vital I	25. Was case referred to medical axaminer?	26. Placa of Death	(Check only one)	
Vision of Vita Attending Physicien: If death. Expert After this certific by the funeral director,	1 ☐ Yes 27 No Hospitat: 1 ☐ Inpatient 2 ☐ ER 27. Menner of Death 28e. Deta of Injury 28	/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 Rasidanca 6 Othar (5	Specify)
ding i	27. Mannar of Death 28. Deta of Injury 28. Deta of Injury (Month, Day Year) 29. Accident invastigation	b. Time of Injury M 28c. Injury at Work?  M 1 □ Yas 2 □ No	od. Dassillo ilov injuly occasion	
Division of the or Attending Program of Director After the or or or or or or or or or or or or or	3 ☐ Suicide 6 ☐ Could not be determined 28a. Pleca of Injury - At home building, etc. (Specify)	, farm, street, factory, offica 2	28f. Location (Street and Number of City or Town, Stete)	r Rural Routa Number,
in of the control of				
Divisit  To the Hospital or Attant within 24 hours elter deat To the Furerel Director: completely filled in by the Madical Certifical	29a. Certifiar 1 Certifying Physician: To tha best of my knowle (Check only one) 1 Medicat Examiner: On the basis of axamination and mannar stated.	Jge, deeth occurred at the time, date and piece, a and/or invastigation, in my opinion, death occurre	and due to the causa(s) and manne ed at the time, dete end place, end	er es stated. dua to tha cause(s)
within 2 To the comple	29b. Signature and title of certifier	29c. Licansa number	29d. Data signad (M	fonth, Day, Year)
	> Amsel M	D16347	6/16	000
10	30. Nama and addrass of person who completed causa of death (Item 23	(Type, Print)	D	
Cont	31. Data filed (Month, Day, Year) 32, Registrary Signetury	LAMEDICAL ST	BALTIMORE	MD2120/
State	111N 1 9 2000	your		

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Delores June 14 2000 Ethel Johnson 10:45pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05 25 7. Age (In yrs. last birthday) 6 Sax Birthplace (State or Foreign Country) **Funeral** 1□M 2XTE Months Days Hours Yrs. 67 218-28-8491 Director M.D. Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits YGYes 2 No Director Baltimore NA 932 Wilmot Court Meritel Stetus 1 □ Never Merried 1 □ Never Merried 1 □ Never Merried 1 □ Never Merried 1 □ Never Merried 1 □ Never Merried 1 □ Yes Name 1 □ Yes Name 1 □ Yes Give Yeer or Detes: 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 Funeral 21202 U.S.A. 14. Race - American Indian, 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th grade Homemaker House na 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 80 and 2 should be saith and Mental James Smith Ruth Harris capartment of Health and Important: If Item 27 is m any injury or other traumants 19e. Informent's Name/Reletionship (Type, Print) Daughter 19b. Meiling Address (Street end Number or Rurat Route Number, City or Town, Stete, Zip Code) 3554 Elmley Ave, Baltimore Md Arnita Johnson-Faleti 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 6/19/2000 Glen Burnie, Md 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility March F/H West 4300 Wabash Ave, Baltimore Md 21215 Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Metastate Colonic Carcinoms Immediate Ceuse (Finel disease or condition resulting in deeth) Medical Examiner Cardwonauler Discore 34RS Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Voscerla 3 Probably 4 Onknown 1 Yes 2 No Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy 1 Yes 2/2(No 1 ☐ Yes of Vital 86 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) 1□ Yes 2000 Other: 10 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 1 Naturel 2 Accident 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Alter Division 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of tnjury - At home, farm, street, tactory, office building, etc. (Specify) after Dire 4 Homicide To the Hospital St. hours a To the Feneral C edical 1 Sertifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Dete filed (Month, Day, Year) JUN 1 7 2000

3400 ERDMON 32. Registrar's Signeture

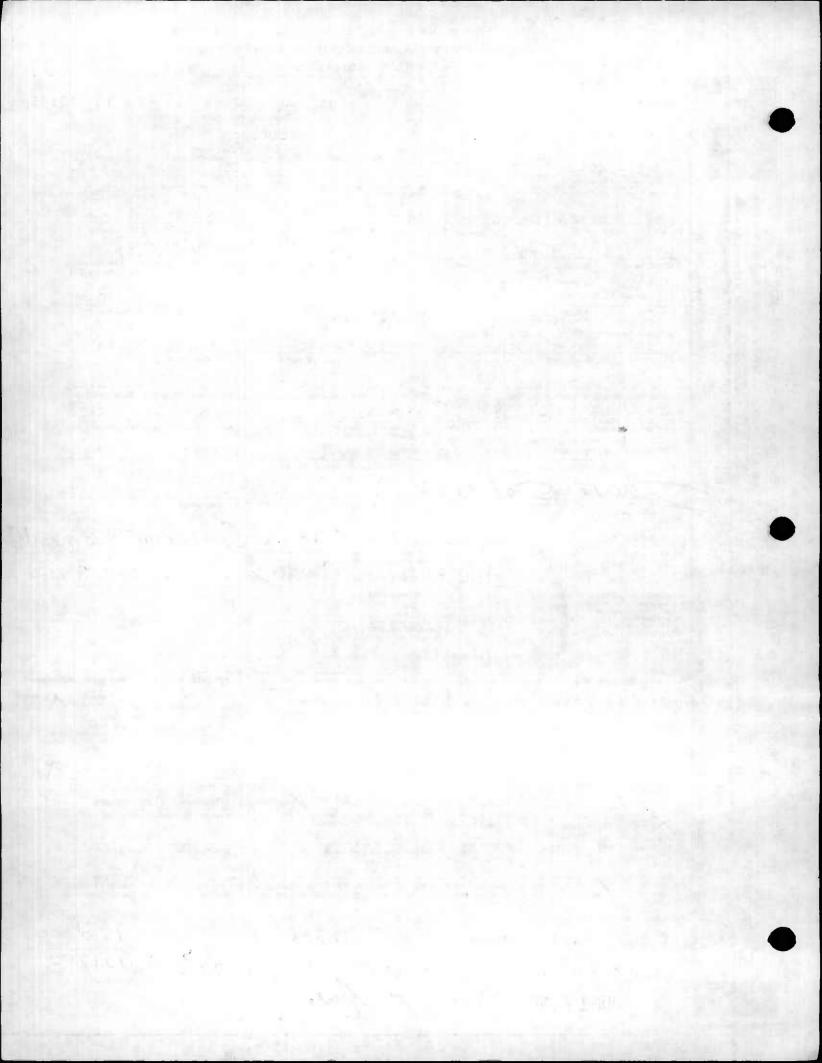
and

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

BALTMORE MD21213 VENUE

30641

June 15 2000



State of Maryland / Department of Health and Mental Hygiene

if Under 1 Yaar

Days

7. Aga (In yrs. last birthday)

70

Certificate of Death 2. Date of Death Month 3. Tima of Death ELMER THEODORE KEYS, JR JUNE 9,

4b. City, Town, or Location of Death

Baltimore

2000

8. Data of Birth (Month, Day, Year) Aug 2, 1929

4c. County of Death

Baltimore

10:10 PM

Birthplace (Stata or Foreign Country)

MD

**Physician** /Medical **Examiner**  1. Decedent's Nema (First, Middla, Last)

GILCHRIST CENTER

5. Social Sacurity Numbar

213-26-8878

4a Facility Nama (If not institution, giva street and number)

6. Sax 1 M 2 □ F

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If them 27 is marked other than "returns!", or items 23a or 28a-f ahow any Injury or other traumatic event. It is it in the statement of the process of the statement of the sta

**Physician** /Medical Examiner

The law requires that the deeth certificate be executed s been signed by t should be detect or Attending Physician: within 24 hours after death. To the Funeral Director: A

Division of Vital Records. P.O. Box 68760.

10a. Stata 10b. County		c. City, Town	or Location				10d. Insida City Limits
MD Balt:	imore	I	Baltimore				1 ☐ Yas 2√ No
10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?
6601 N. Charles	Street		2	1204		***	2.4
1. Marital Status	12. Was Decedant Evar	In U.S.	13. Was Decedent of H		Specify Yas or No-		SA a - Amarican Indian,
1 ☐ Nevar Married 2 ☑ Married	Armed Forcas? 1 ☑ Yas 2 ☐ No		If Yas, specify Cubi	an, Mexican, Puar	to Rican, atc.)	Blac	k, Whita, atc.
3 Widowed 4 Divorced	H Van Civa	51-53	1 ☐ Yas 2 📉 No	Specify:			white
15. Decedent's ( (Specify only highast g	Education grada completed)	16a.	Decedent's Usual Occup (Give kind of work done	during most of wo	rking	16b. Kind of Bu	siness/Industry
Elementery/Secondary (0-12)	Collega (1-4or 5+)		lifa. DO NOT use retired				
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17. Fathar's Name <i>(First, Middla, Las</i> Elmer T. Keys	11)				ma (First, Middle, • Gaglia:		Θ)
19a. Informant's Name/Ralationship	(Type, Print)	19b.	Mailing Address (Street				Stete, Zip Code)
Ann Keys/spouse		1	3802 Prince	ee Anne	Way Pho	enix, M	D 21131
20a. Mathod of Disposition	2'	0b. Place of	Disposition (Nama of		Data		City or Town, State
1 ☐ Burial 2 ☐ Cramation 3 4 ☒ Donation 5 ☐ Other (Spec		cemetar	y, crematory or other plac	>e)   			
21. Signature of Euneral Sarvice Lice RONALD	wade, Direct	or	State Ana Baltimore		rd 655 W.	. Baltin	nore Street
23a. Party. Entar the disaase, or co	mplications that causad tha	daath. Do n				rast,	Approximata
shock, or haart failure. List on	y ona ceuse on aech lina.						Interval Between Onset end Death
Immediate Causa (Final	1 000		Dicto	rudi	10010		1 0100
disaese or condition rasulting in daeth)	a. COVO	NAV	7 7012	100	JEMJE		genrs
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cause. Entar Undarlying Cause (Disease or Injury	6						
that initiated events rasulting in death) Last	Dua	to (or as a c	onsequence of):				
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Part II. Other significant conditions	contributing to death but no	t resulting in	the underlying causa giv	en in Part I.	23b. Dld t	obacco use co	ntribute to the cause of death
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					pertor	med?	available prior to completion of cause of death?
25. Was need referred to modified				oc Physical P	pertor	ras 201No	available prior to completion of cause
25. Wes casa raferred to medical axaminar?	Hospital:		Ort	or	pertor	med? 'as 'No	available prior to completion of cause of death?
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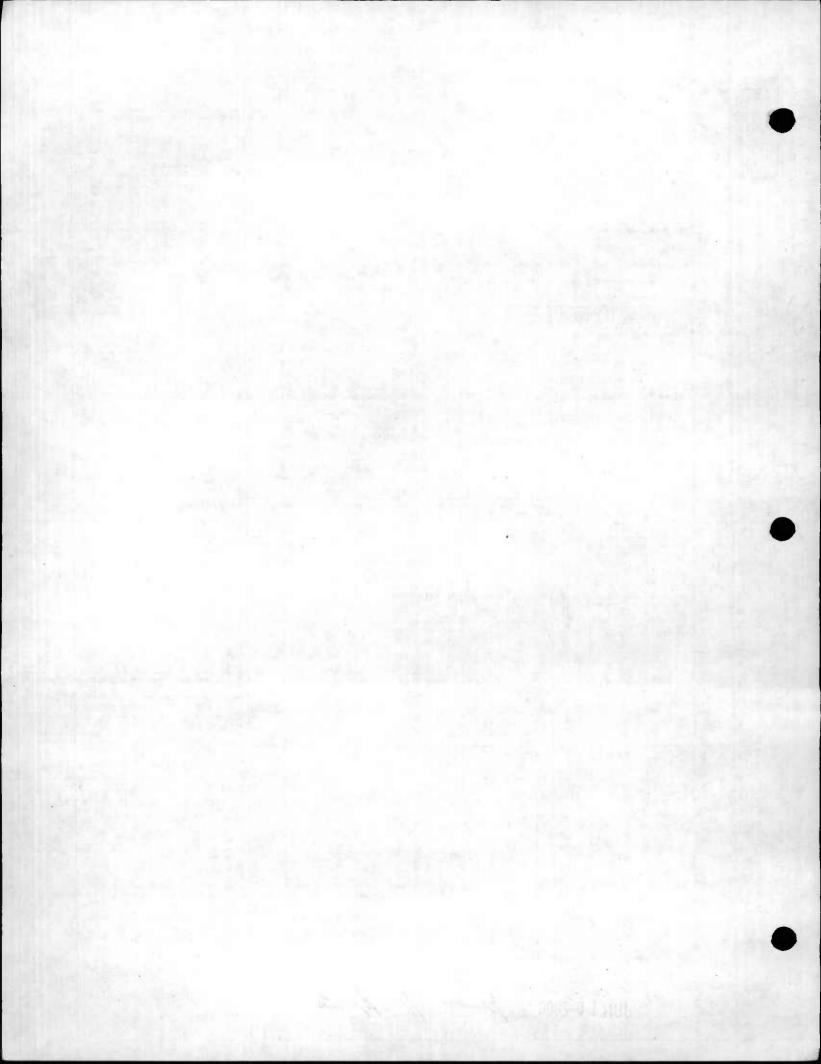
DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

JUN 1 9 2000

32. Registrar's Signetura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9299 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY 29, Year **Physician** 2000 9:50 AM MARIA G. KENDALL /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 321 Brewington Drive Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Months 1 □ M 2 🛛 F 521-40-2125 Yrs. Director 78 DEc 8, 1921 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Director Wicomico Salisbury 288-5 the Medical Exactions must be notifi-10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Terra 23s or 21801 321 Brewington Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: 1 Never Married 2 Married b 1 ☐ Yes 2 No Specify: Specify: À white 3 Widowed 4 □ Divorced 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be find within Department of Health and Mental Hygiene important if frem 27 is marked other than any injury or other traumetic. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 housewife none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Giovanni Moretti Caterina Silvestri 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Kendall/daughter 321 Brewington Drive Salisbury, MD 21801 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☑ Donation 5 ☐ Other (Specify) Signature of Funerel Service Licensee 22. Name end Address of Facility Ronald S. Wade State Anatomy Board 655 W. Baltimore Street noen Baltimore, MD eales 21201 234 Pt 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, and es cardiec or resistance, or heer failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and **burial-trar** Physician/Medicai the Due to (or as a consequence of) USe as ŏ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? detached the ZIZNO 3 Probably 4 Unknown signed by 1 Yes p should be 24b. Were autopsy findings evallable prior to completion of ceuse of death? Completed 24e. Wes an autopsy peen performed' page 2 has 1 Yes 20110 1 □ Yes 2 □ No. cartificate director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) 2000 2 1 Yes 3□ DOA 1 Innatient 2 ER/Outpetient After this funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: - Intural 5 Pending 1 Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Af home, farm, streef, facfory, office building, etc. (Specify) 4 Homicide Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

[2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

Maryland 21215-0020

Baltimore,

the filed within 72

certificate be executed Division of Vital Hospital or Attending Physician: after death. 24 hours a within 2 To the To the

> State Registrar

(Check only one)

29b. Signature and Attle of gartifie

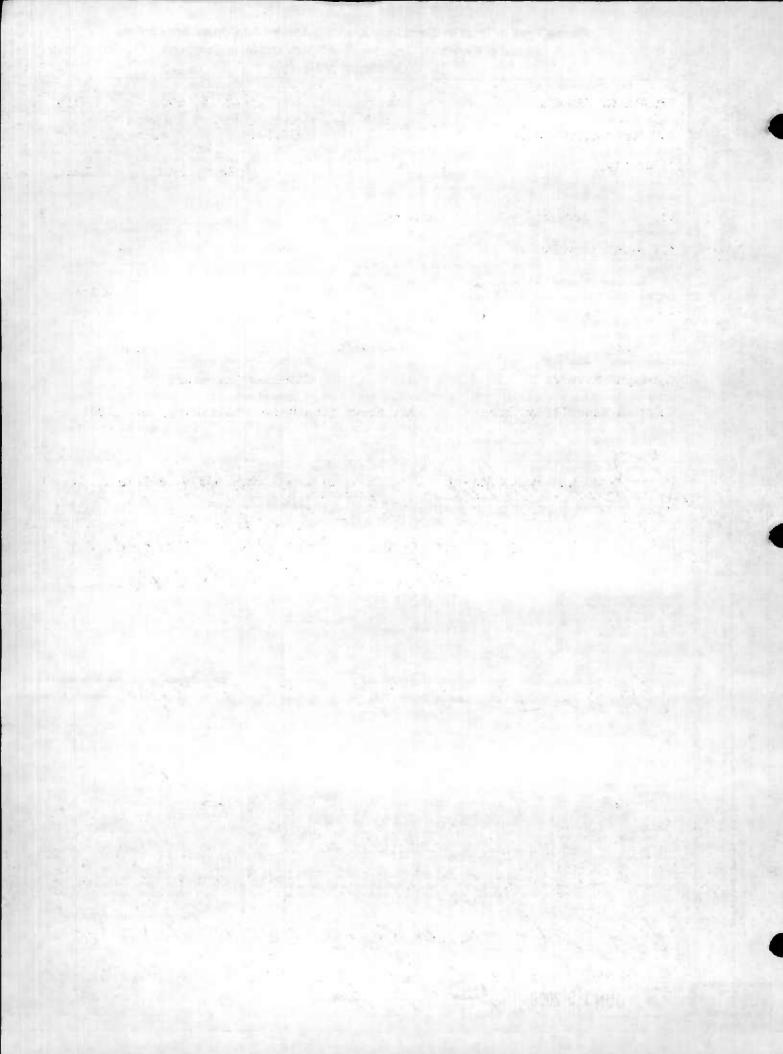
address of person who completed cause of death (Item 23a) Type Print

32. Registrer's Signature

29c. License number

531

29d. Date signed (Month) Day, Year)



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 2000 ear 9, 1:53 P.M. Norma Louise Watson Killebrew 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Upper Marlboro Prince George's 1707 Mallard Court If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number If Undar 1 Yaar 7. Age (In yrs. lest birthday) Birthplaca (State or Foreign Country) Months Days 59 577-54-6527 Jan. 6, 1941 Washington, D.C. Usuei Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No MD Prince George's Upper Marlboro 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 1707 Mallard Court 20774 U.S.A. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Biack, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Banking Industry Private 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middia, Meidan Sumeme) William Norman Watson, Sr. Ray Arlette Johnson Watson 19a. informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Michelle Killebrew-Ervin 1707 Mallard Ct., Upper Marlboro, MD 20774 - Daughter 20b. Pieca of Disposition (Neme of cemetery, cremetory or other piace) 20a. Method of Disposition 20c. Location - City or Town, State X□ Buriai 2 □ Cremetion 3 □ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) Washington National Cemetery Suitland, MD 22. Name and Address of Fecility Latney's Funeral Home, Inc. 21. Signature of Funeral Sarvice Licansee A-cc0348 3831 Georgia Ave., NW, Wash., DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth BNEAST OSCILLONA NEGASTATIO immediate Cause (Finei disaese or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence ot): Dua to (or as a consequence of): rasulting in death) Lest Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy 30 No 1 ☐ Yes 2 ☐ No 25. Was case raferred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1□ Yes 20 No 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28c. injury at Work? 27. Menger of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 1 Yes 2 No

gred by the attending physician and be detached for use as the burial-transit requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by peed certificate has #4 Attending

**Physician** 

/Medical Examiner

> Examiner Physician/Medical þ Completed Be 2

> > edicai

Attac death. after death Director: Hospital 24 hours a Funeral

**Physician** 

/Medical

Examiner

Director

Funeral

\$

Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

To the State Registrar

24

5 Pending investigation 2 Accident 3 Suicida

4 Phomicide

29b. Signature end title of certifier

29e, Certifier (Check only 6 ☐ Could not be detarmined

28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Straet end Number or Rural Route Number, City or Town, Stete)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) manner stated.

FT. WAShington sun 20144

29d. Date Wined (Month, Day, Year)

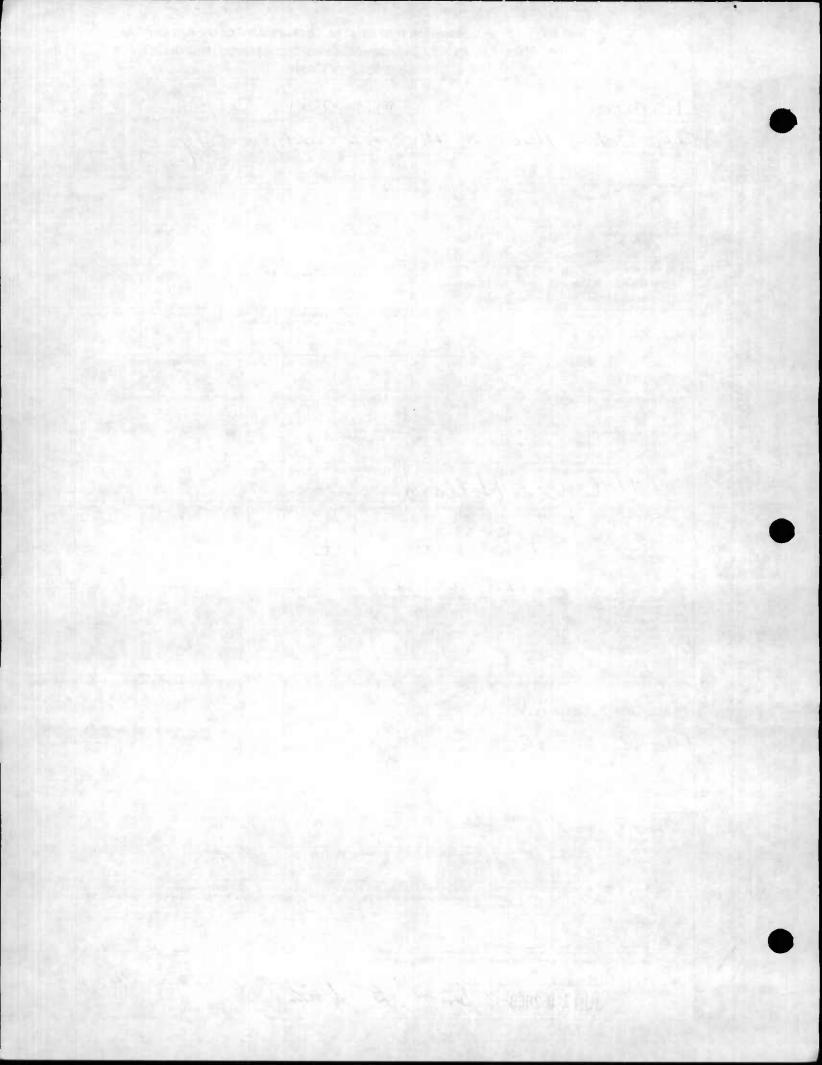
ited causa of death (item 23e) (Type, Print) Livington 11701

32. Registrar's Signetural

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State of Maryland / Department of Health and Mental Hygiene 19301

			Certificate of Death	Reg. No.	12001
	Dhysician	Decedent's Name (First, Middle, Last)		2. Dete of Death Month Dey Yee	3. Time of Deeth
	Physician /Medical	Nannie	Mitchell	June 16 2001	1 / / 3
	Examiner	4a Facility Neme (If not institution, give street and number)	4b. City, Town, or		
		The Johns Hopkins +	osp Hat Datting	one City NA	
	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. Ia 20 - 20 - 9766 1 M 20 F 71	Yrs. Months Deys Hours Min.		Birthplece (State or Foreign Country) MD
	D A.	Usual Residence of Decedent  10a. Stete 10b. County 10c. City,	Town or Location		10d. tnside City Limits
	Many Hada Beda	MD NA Bal	timore		1 Yes 2 No
	or 28e4 s be notified Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What	Country?
		900 N. Luzerne Avenue	21205	USA	
	r hams 23 inst. must Funeral	11. Meritel Status 12. Was Decedent Ever in U,S Armed Forces?	<ol> <li>Wes Decedent of Hispenic Origin? (S If Yes, specify Cuben, Mexican, Puer</li> </ol>	pecify Yes or No- to Ricen, etc.) 14. Reca - Ar Bleck, WI	merican Indien, hite. etc.
21215-0020	by by	1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give Year or Detes:	1 ☐ Yes ŽŽNo Specify:		Black
15-	ed within 72 ho yglene. wer then "netur it, the Medical.	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rking 16b. Kind of Busines	is/Industry
112	the Man	Elementery/Secondary (0-12) College (1-4or 5+) 12th Grade 1 yr.	Day Care Provide	r in home	
D		12th Grade 1 yr.  17. Father's Neme (First, Middle, Last)		me (First, Middle, Maiden Sumeme)	
Maryland	Mental H Mental H info off rice ever To Be	Phil Stokes	Nanni	e Brown	
ary	and the man	19a. Informent's Neme/Reletionship (Type, Print) Clark	19b. Meiling Address (Street and Number or Ri		, Zip Code)
	and 2	Patricia Davis+Sandra	428 Middleton Lan	e Aberdeen, Mar	ryland 2100
altimore,	of He	20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removal from State	ece of Disposition (Name of metery, crematory or other place)	Dete 20c. Location - City of	or Town, Stete
E	Pag ment ant: 1	4 Donetton 5 Other (Specify)	ownsville VA Cem.	06-21-2000 Crow	nsville, MD
Ball	Depart Depart Import any in	21. Signeture of Funeral Service Licensee	22. Name and Address of Fecility B	altimore, Maryl 1101 E. North	
		23a. Pert1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not en rithe mode of dying, such es cardia	c or respiretory errest,	Approximate Interval Between
	Physician	Show, of floor foliation. List only one cause of each line.			Onset end Deeth
	/Medical Examiner	Immediate Ceuse (Finel disease or condition seculiar in death)	Brain Event		Slohars
			as a consequence of):		36 hours
	executed in and istransit	b. hemorrh			; 36 hours
	al-tra	Sequentially list conditions, if any, leeding to immediate	as a consequence of):		
68760,	certificate be executed right physician and use es the burial-transit and the control of the con	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or	es a consequenca of):		
	g phy es th	resulting in death) Last	os a consequenca orj.		
Вох	ending r use	d			1
	deeth etterned for u	Part II. Other significant conditions contributing to death but not result	ting In the underlying cause given In Pert I.	23b. Did tobacco uee contribu	ute to the cause of death?
P.0	The law requires thet the deeth certific cate has been signed by the attending page 2 should be detached for use es Completed by Physiclan/Mex	diabetus mellitus		1 □ Yee 2 Ø No 3 □	Probably 4 Unknown
ŝ	tigned be d	Olaberus Hellins			
Records,	w requires that is been signed is should be det	Coroner arteridigano		24a. Wes en eutopsy performed?	b. Were autopsy tindings avellable prior to completion of cause
3ec	has be 2 s	and a solid			of death?
	cate h			1 ☐ Yes 2,2 No	1 ☐ Yes 2 ☑ No
of Vital	Physician: The law this certificate has trail director, page 2 s. To Be Compi	25. Wes case referred to medical examiner?	Other:	eth (Check only one)	
o	Physic rthis constitution and direction T: To	12 Inpatient 2 LE	Produpetient 3LI DOA 4LI Nursing P	lome 5 ☐ Residence 8 ☐ Other (S) 28d. Describe how injury occurred	oecify)
on	ding th. Afte fune	27. Menner of Death  1. Neturel 5 □ Pending (Month, Day Year)  2 □ Accident investigation	28b. Time of lnjury at Work?  M 1 Yes 2 No		
Division	after death. Director: After I in by the fune	3 Suicide 6 Could not be determined 28e. Plece of Injury - At hor	ne, ferm, street, fectory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
Ö	tai or Attending P is after death. all Director: After t led in by the funers Certification:	4 Homicide building, etc. (Specify)		City of Town, Stelle)	
	ne Hospit n 24 hour ne Funera pletely fill edical	29a. Certifier (Check only 2 Medicat Examiner: On the basis of examinetic			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 3	one) and manner steted.			
	o t vit	290. Signature and Hiller of certifier	29c. License number	29d. Date signed (Mo	ntn, Day, Year)
	1	there	KES-001	June	16,2000
	11	30. Name and address of person who completed cause of deeth (Item:	23e) (Type, Print)	Baltmore M	nule
	Con	31. Dete filed (Month, Day, Year) 32. Registrar & Signatu	DNoth Will Sheet	Ballmore 11	rylung
	State	11N 1 9 2000 Dens	D sports		



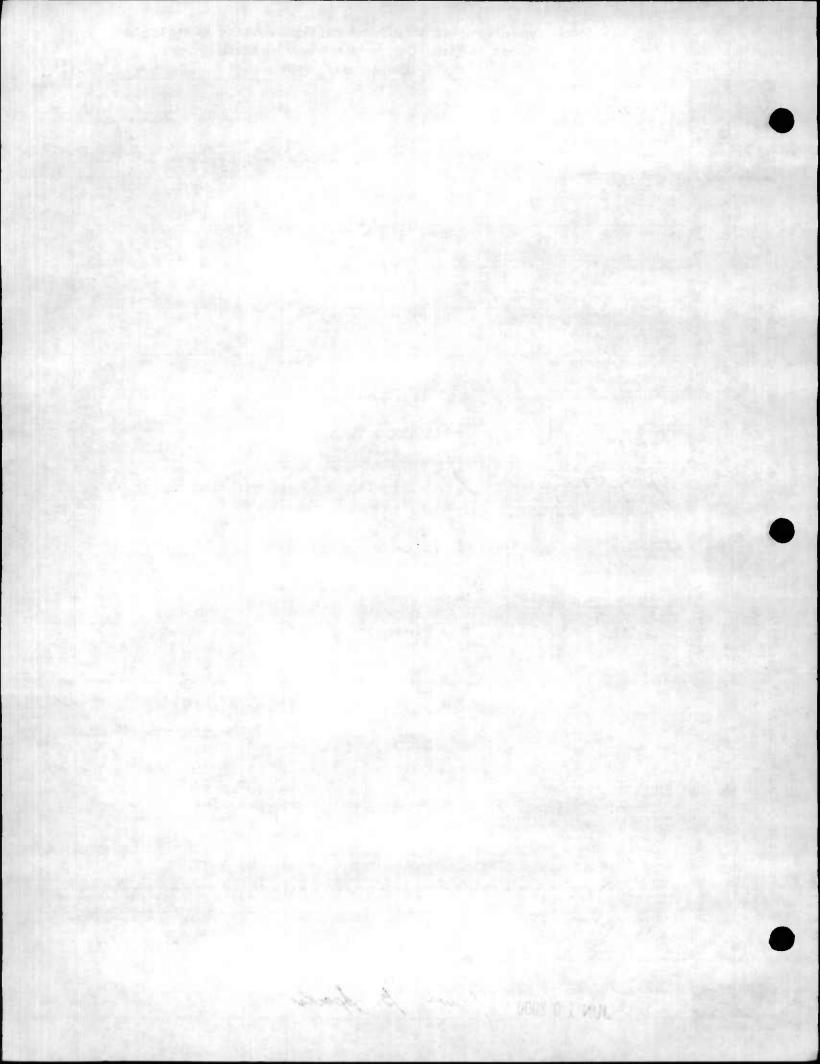
Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

AMEND IT	TEM: #5 PER F.H. GZ784 6-27-00 WR. Certificate of Death  1. Decedent's Nama (First, Middla, Last)	2. Data of Dec	Reg. No.	19302 3. Time of Death		
nysician Medical kaminer	ANDREW HENRY MAGGITTI  4a Facility Nama (If not Institution, giva street and number)  4b. City, Town, or L	JUNE	Day 18 2	Year 18:22		
ral lor	To Has Hapitans Dayview Medical Center BALTING  5. Social Security Number 6353 1風M 2口F 7. Aga (In yrs. last birthday) H Undar 1 Year If Undar 24 Hrs. Months Days Hours Min.  213-16-6352  Usual Rasidence of Decedent		h y, Yaar)	9. Birthplaca (Stata or Foraign Country) Steubenville, Ohio		
rai Director	10a. State 10b. County 10c. City, Town or Location Baltimore			10d. tnslde City Limita 1☑ Yas 2☐ No		
al Director	10e. Street and Number 10f. Zip Coda 253 South Conkling Street 21224		10g. Citizen of W	/hat Country?		
by Funeral		r in U.S.  13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.)				
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ro Be Co	17. Fathar's Nama (First, Middla, Last) Pete Maggitti  Maria M.		Maidan Sumam	a)		
	19a. Informant's Name/Raletionship (Type, Print) wife Amelia Maggitti 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place)		more, M			
	1 ☑ Burlat 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify)  21. Signatura of Funaral Service Licensea  22. Nama and Addrass of Facility Joseph 263 South Conkling Street	seph N. Za	nnino Jr.			
n/Medical Examiner	disasas or condition rasulting in death)  a. CEREBRONASCNLAR ACCIDENT  Dua to (or as a consequence of):  ATMCROSCLEROTI C MISSEASE  Dua to (or as a consequence of):  Course (Disesse or Indurfying Course (Disesse or Indury that initiated avents rasulting in death) Last  d.					
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Completed by			an autopsy ormad?	24b. Wara eutopsy findings available prior to complation of causa of death?		
Be Con	25. Was casa rafarrad to medical examiner?	1 □		1 □ Yas 2 No		
0		28d. Dascribe				
Medical Certification:	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred and mannar stated.	e, and due to the	cause(s) and me			
Me	29b. Signatura and titla of certifier  29c. Licansa number  RES - 233  30. Nama and nurass of person who complated causa of daath (Item 23a) (Type, Print)		29d. Data signad	(Month, Day, Year)		
State	31. Deta filed (Month, Day, Year)  32. Registrar's Signatura	CNTER.				

State Registrar

DHMH 16 Rev 6/95

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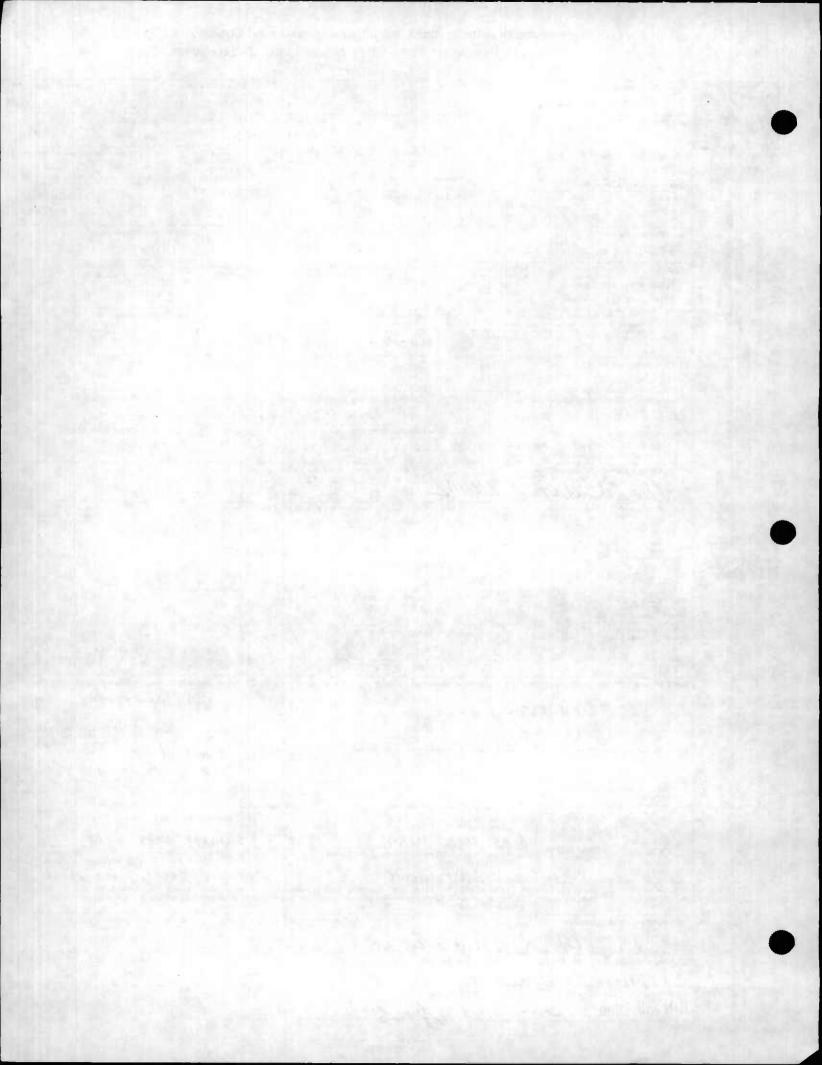
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State of Maryland / Department of Health and Mental Hygiene

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ledical	Kyle Ow										JUNE	0	)5	2000	19:50
miner	4a Facility Name				mber)					or L DLUM	ocation of Dea	ath 4c	:. County HOW?	of Death	
	5. Social Securit	ACE CHI	6. Sax	COURT	7. Aga (In vn	s. last birthday	) If Unda	r 1 Yaar	-		8 Data of B	lirth			iace (State or For
ral tor	218-11-4			M 2□ F	26	Yrs.	Months	Days	Hours	Min.	9-19th f	973	)	Penns	
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irector	MD	Howar				lumbia	oouton.						10d. Inside City Lim 1 ☐ Yas 2X		
- ct	10e. Street and		u		003	Cumbia	10f. Zip	o Code			10g. Citizen of What 0			What Coun	try?
Funeral Director	100000000000000000000000000000000000000	ace Chi	mes (	Ct.				1045	5			-	S.A.		
ner	11. Marital Statu	s	12	. Was Dec	edent Evar in	U,S. 13.	Was Dece	dent of I	Hispanic Ori	igin? (Sp	Decify Yas or N	lo-		e - Amaric	
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eted	(S)	15. Decede				(Giva	edent's Usu a kind of wo	ork done	during mos	t of work	king	-		usinass/Inc	
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Ö	17. Father's Nam	e (First, Middla	, Last)								a (First, Middle	le, Maider	n Suman	10)	
reumetic event, To Be C	Willie	Owens M	larti	in Julia					la S	tevens					
	19a. Informant's										Aural Routa Number, City or Town, State, Zip Coda)  Columbia, MD 21045				Coda)
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1	21. Signature of	Funeral Service	Licensep			2	2. Nama ar	nd Addre	ess of Facili	ty	The same				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death June 15, 2000 **Physician** 2:45 PM GERTRUDE **MERRYMAN** CATHERINE /Medical 4c. County of Death 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Baltimore Good Samaritan Hospital If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) July 11,1911 Birthplece (State or Foraign Country) 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Months Deya Hours 1 M 2 F 212-07-2555 88 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mental Hygiene. Important: If Itam 27 is merked other than "natural! -- " any injury or other traumetic average. 10d. Inside City Limits 10a. Stete 10b. County 10c. City. Town or Location Baltimore City 1 ¥ Yas 2 □ No Maryland N/A Funeral Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? U.S.A. 6401 Loch Raven Blvd. Apt. 142 21239 13. Wes Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indian, 12. Wes Decedent Ever in U.S. Armed Forces? Bleck, White, etc. 1 Yes 2 No If Yas, Giva X Year or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify: p Specify: 3 ☑ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) Home Maker 12 yr's Own Home 17. Father's Neme (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Surnama) John Forestell Ann UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Mr. David Merryman - Son Hampstead, MD 747 Clearview Avenue 21074 20b. Place of Disposition (Neme of cematery, crematory or other pleca) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Crametion 3 ☐ Removet from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Moreland Memorial Park 6/19/00 Baltimore, MD 21. Signeture of Funeral Service Licensee 22. Nama and Address of Facility Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Pert1. Enter the disease, or complications that a pool the deeth. Do not enter the mode of dying, such as cerdiac or respirelory arrest, shock, or heart feiture. List only one causa on enter the Approximete Intarval Batween Onset end Death **Physician** Immediate Cause (Finel diaeesa or condition resulting in death) /Medical . Acute Myocardial Examiner Due to (or es a consequence of): Physician/Medical Examiner The law requires that the deeth certificate be executed ed by the attending physician and deteched for use as the burial-tran-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequance of): Box 68760. Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? this certificate has been signed by rail director, page 2 should be detect 1 □ Yes 2 □ No 3 □ Probably TUnknown Division of Vital Records. PV 24b. Wara autopsy findings available prior to completion of cause of daeth? 24a. Was an autopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No I or Attanding Physician: after death. funeral director, 25. Was casa referred to medical 26. Placa of Death (Check only one) Hospitet: 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Yes 2N No Manner of Deeth 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No neral Director: A 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stele) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicida To the Hospital of within 24 hours a To the Funeral D completely filled in 29a. Certifier TX Certifying Physician: To the best of my knowledga, deeth occurred at the time, date end plece, end due to the ceuse(s) and menner es stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) Medical end menner steted. 29b. Signature and title of 29c. Licansa number 29d. Dete signed (Month, Day, Year) 16 JUNE 2000 17041 30. Nema and addrass of person who completed ceuse of death (ttem 23a) (Type, Print) STE 38. LUTHERVILLE MY 21093 1205 YURK ROAD MO MARC I. LEAVEY

**DHMH 16 Rev 6/95** 

State

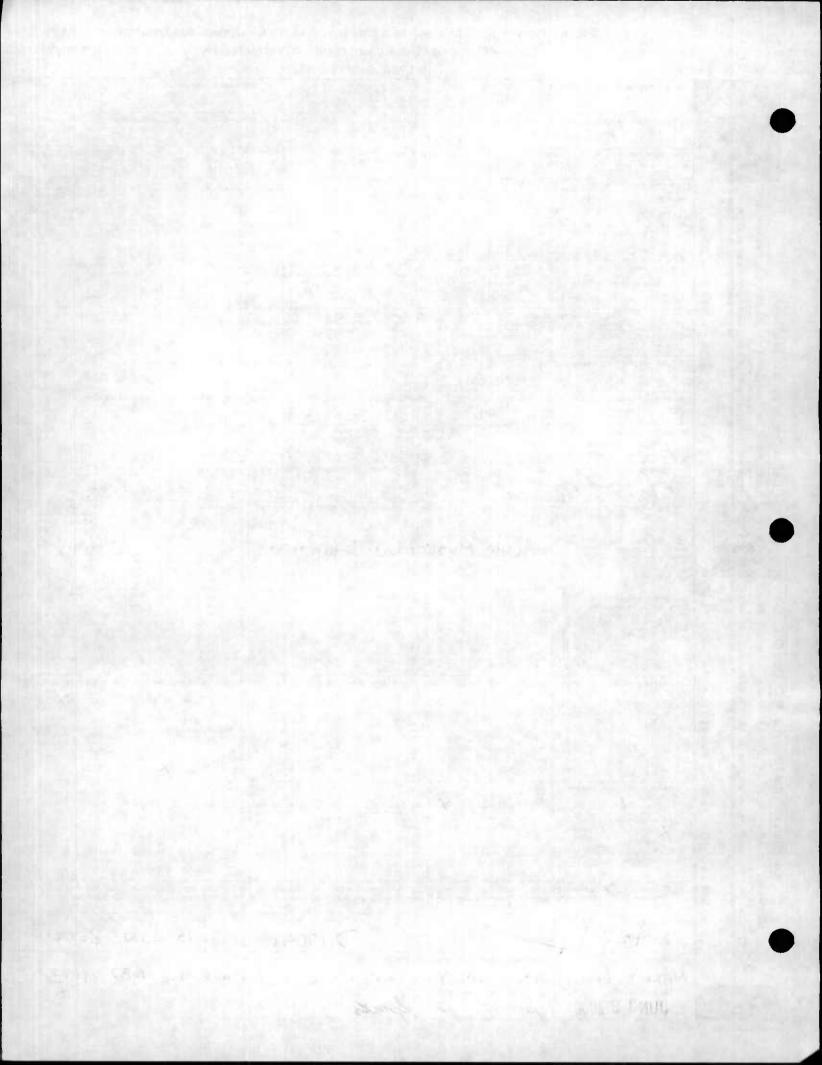
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31. Data filed (Month, Day, Year)

JUN 1-9 2000

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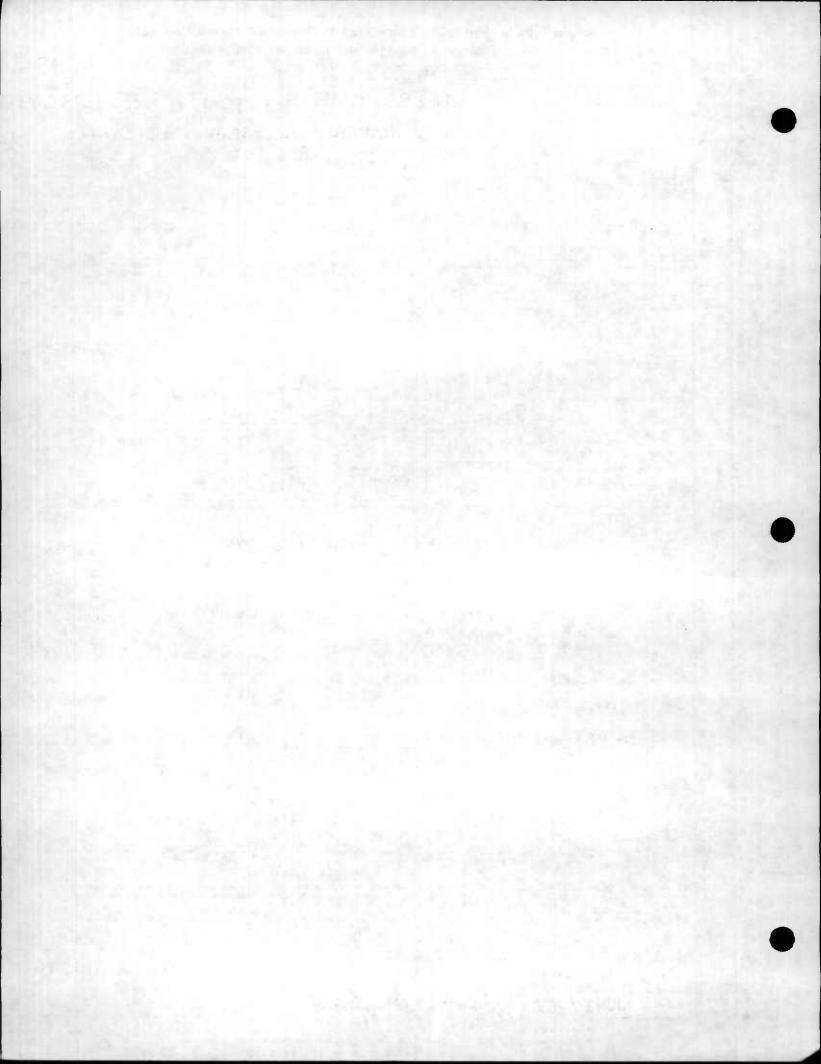
32. Registrer's Signeture



The Section Present Principle of Section Presented and number?  ## Feetiley Name (Free Institution Presented and number)  ## Section Present Principle of Section Present Principle of Section Proceedings of Principle of Princip	MEND IT	EM: #23A PER PHY		7-00 WR	, Cert	ificate o	f Death		Reg.	No. U		9305
HOUGH COUNTY GROWN	Physician /Medical		(e, Last)	MI	ELBO	URN		JNO	)N	11 20	000	3. Time of Death 3:35 AM
5 Social Society Numbers 6 Save 37 None of Programs and ormotory 1 Fluther 1 year 1 Fluther 2 Has 1 Fluther 2 Has 1 Fluther 2 Has 1 Fluther 2 Has 1 Fluther 2 Has 1 Fluther 2 Has 1 Fluther 2 Has 1 Fluther 2 Has 1 Fluther 2 Has 1 Fluther 2 Has 1 Fluther 2 Fl	Examiner		n, give street and num	ber) ENER	AL HI	OF INC						20
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Month   Royard   Columbia   10, 26 Code   105 Cities of What Country   105 December   105 Cities   105 December   105 D		Usual Residence of Decedent		10c City	Town or Loca	ation					110	Od Inside City Limits
912.1 Gracious End Court \$10.5  11 Institution Studies  12 Was Deceded for in U.S.  12 Was Deceded for in U.S.  12 Was Deceded for in U.S.  13 Was Deceded for in U.S.  14 Institution Studies  15 Deceded for in U.S.  16 Rece. American Indian, etc.  17 Sept. S	tor		ъъ									
19   11   Maria Status   12   Was Deceded For in U.S.   13   Was Deceded for Septiment of Septiment Origin? (Specify Yea or No. 14   14   No. 15   14   No. 15   No	lirec			COI	undia	10f. Zip Code			10g.	Citizen of W	/hat Coun	itry?
Specify White   Specify		9121 Gracious I	End Court	102								
16a Decidents Education   16b Kind of Business/Industry   16		1 Nevar Married 2 Mar	Armed Fore	ces? ☑ No	lf.	Yes, specify Co	uban, Mexican,	in? (Specify Ye Puerto Rican, o	s or No- etc.)	Blac	k, White,	etc.
Nother's Name (First, Modity, Last)   Herbert Earnshaw   15. Meding Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   Jane Bailey daughter   26.29 Melba Road, Ellicott City, Maryland 21.042   20s. Method of Disposition   Signature of Disposition   Signature of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Disposition   Date   20s. Lector of Date   2		15. Deceden	it's Education		16a. Decede	nt's Usual Occ	upation	of working	168	b. Kind of Bu	_	
Berbert Earnshaw   18. Mother's Name (First, Modifie, Last)   19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   26.29 Melba Road, Ellicott City, Maryland 21.042   20. Melba Of Disposition   19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   20. Melba Of Disposition   20. Melba Of			College (1-	4or 5+)	life. De	O NOT use reti	ired)	or working				
Herbert Earnshaw   Set   Informant's NamoRelationship (Type, Print)   19th Mailing Address (Street and Number or Plust Route Number, City or Town, State, 2p Code)   19th Mailing Address (Street and Number or Plust Route Number, City or Town, State, 2p Code)   262.9 Melba Road, Ellicott City, Maryland 21042   20th Method of Disposition (Numer of combets), Generally or Shelp place)   20th Date of Disposition (Numer of combets), Generally or Shelp place)   20th Date of Chesposition (Numer of combets), Generally or Shelp place)   20th Date of Chesposition (Numer of combets), Generally or Shelp place)   20th Date of Chesposition (Number of Pack)   20th Date of Chesposition (Numer of combets), Generally or Shelp place)   20th Date of Chesposition (Numer of Chesposition (Nume		17. Father's Name (First, Middle,			Judge		18. Mother	's Name (First,				t System
Jane Bailey daughter  20s. Nethod of Disposition 10 Busile 2 @Cremation 3   Bemoval from State 4   Donation 5   Other (Specify) 4   Donation 5   Other (Specify) 4   Donation 5   Other (Specify) 5   Other (Specify) 21. Signshift of Fungers   Springe Ligorises 4   Donation 5   Other (Specify) 22. Nama and Address of Part   Early Ingrides of Completed on the Complete of Caste Science of Springers   23. Part   Early Ingrides   Other (Specify) 24. Nama and Address of Part   24. Part   Early Ingrides   Other (Specify) 25. Part   Early Ingrides   Other   Other   26. Part   Early   List only one cause on each   26. Part   Early   List only one cause on each   26. Part   Early   List only one cause on each   26. Part   Early   List only one cause on each   26. Part   Early   List only one cause on each   26. Part   Early   List only one cause on each   26. Part   Early   List only one cause on each   26. Part   Early   List only one cause on each   26. Part   Early   List only one cause on each   26. Part   Early   List only one cause on each   26. Part   Early   List only one   26. Part   Early   List only one   26. Part   Early   List only one   27. Nama   List one   28. Part   Early   List only one   28. Part   Early   List only one   29. Part   Early   List one   29. Double   Cause   Early   29. Double   Cause   Early   29. Double   Cause   Cause   29. D							-					
20. Method of Disposition 1 Blurial 2 & Corenation 3   Removal from State 4   Donostion 5   Other (Specify) 4   Donostion 5   Other (Specify) 4   Donostion 5   Other (Specify) 4   Donostion 5   Other (Specify) 4   Donostion 5   Other (Specify) 4   Donostion 5   Other (Specify) 5   Donostion 5   Other 5   Other 1   Other algorithcart conditions that cause of bedath. Donost enter the mode of dying, such as cardiac or respiratory arrest, indicated a contribution of the cause of dying such as cardiac or respiratory arrest, indicated a contribution of the cause of dying such as cardiac or respiratory arrest, indicated a contribution of the cause of dying such as cardiac or respiratory arrest, indicated a contribution of the cause of dying such as cardiac or respiratory arrest, indicated a contribution of the cause of dying such as cardiac or respiratory arrest, indicated a contribution of the cause of dying such as cardiac or respiratory arrest, indicated a contribution of the cause of dying such as cardiac or respiratory arrest, indicated a contribution of the cause of dying such as cardiac or respiratory arrest, indicated a contribution of the cause of dying such as cardiac or respiratory arrest, indicated a contribution of the cause of dying such as cardiac or respiratory arrest, indicated a contribution of the cause of dying such as cardiac or respiratory arrest, indicated a contribution of the cause of dying such as cardiac or respiratory arrest, indicated a contribution of the cause of death of the cause of death of the cause of death of the cause of death cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Stre	et and Number	r or Rural Route	Number, C	ity or Town,	State, Zip	Code)
Comparison   Com			daughte				Road, E			_		
21. Signals/file of Funerial Service Licentees    22. Name and Address of Facility   DonaldSoon Fruneral Home, P.A.		1 ☐ Burial 2 ☐ Cremation		tate	emetery, crema	atory or other p	212					
23s. Part. Fine the fishers or complications that caused the death. Do not enter the mode of dying, such as cardies or respiratory arrest.    MRSA			-	Met					/UU Ca	iconsv.	rrre,	Maryiand
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate finding the standard of the stan		1 1/1-41	WIL	M0077	^				-		3 207	1200
Immediate Cause (Finel disease or condition resulting in death)   Due to (or as a consequence of)		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca			the mode of d	Ving, such as o	cardiac or respli	ratory arrest	ryland	1_201	Approximate
Due to (or as a consequence of):  A SPIRATION PNEUMONIA  3 WEEK  Sequentially list conditions		Immediate Cause (Finel disaese or condition										
Cause (Disease or Injury that Initiated events resulting in death) Last  Due to (or as a consequence of):  COPD  Part fl. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  DIABETES  Part fl. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  DIABETES  Due to (or as a consequence of):  20 YEAR  23b. Did tobacco use contribute to the cause of death of the cause o	ĕ	resulting in deeth)	Λ.						131		1	0
Due to (or as a consequence of):    COPD	Ē	Convention, list conditions	6				UMONIA				- 14	3 WEEK
Due to (or as a consequence of):  COPD  20 YEAR  20 YEAR  21. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  DIABETES  DEPRESION  24b. Were autopsy finding available prior to completion of cause of death?  1 Yes 2 No 1 Yes		if any, leading to immediate cause. Chicago the leading to immediate	SI	MALL	BOU	NEZ	OBS7	RUCTION				1 MONT
Part fl. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.    23b. Did tobacco use contribute to the cause of death	5	that Initiated events	c.			ence of):		0.6112				
DEPRESSION  24a. Was an autopsy performed?  24b. Were autopsy finding available prior to complation of cause of death?  1	-Me		d	COP	D						12	20 YEARS
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25. Was case referred to medical examiner?  1   Yes   20   No	y Phys	DIABE	TES						17			bably 4 ☐ Unknow
25. Was case referred to medical examiner?    Yes   20 No	pieted t	DEPRE	2510N					24	a. Was an a	autopsy d?	av	allable prior to mplation of causa
25. Was case referred to medical examiner?  1	Com								1 🗆 Yas	2 12 No	10	Yas 20 No
27. Manner of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)	Be	examiner?	Hospital: /					of Deeth (Chec	ck only one)			
29b. Signature and title of certifity  29c. License number  29d. Date signed (Month, Day, Year)  TWE 11, 2000  30, Name and address of person who completed cause of death (Item 23a) (Type, Print)		27. Manner of Death  1 Netural 5 Pendir	28a. Date of		28b. Time of	28c. Ir	njury at Vork?	28d. De				
29b. Signature and title of certifies  29c. License number  29d. Date signed (Month, Day, Year)  TWE 11, 2000  30, Name and address of person who completed cause of death (Item 23a) (Type, Print)	ertifica	3 Suicide 6 Could	not be				28f. Lo Cit	28f. Location (Street and Number or City or Town, State)		er or Rura	I Routa Number,	
29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year)  TWE 11, 2000  30, Name and address of person who completed cause of death (item 23a) (Type, Print)	dical	(Check only 2 Medical	Examiner: On the bas	sis of exeminet	viedge, death ion end/or inve	occurred at the estigation, in m	time, date and y opinion, deatl	d pleca, and due h occurred at th	to the ceus e time, dete	se(s) and me and plecs,	nner as s and due to	tated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	M	29b. Signature and title of certific	tin		1721			. 6	29d	. Date signed	d (Month,	Day, Year)
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				of death (Item	23a) (Type, P	VNAPO	ous k	ed e	110	TTCI	א צר	10 21042

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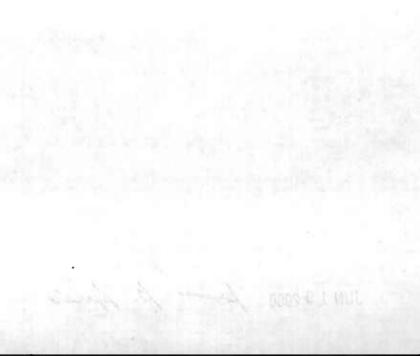


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death **Physician** ADELAIDE JOHNSON MAYO 2000 14 3:35PM June /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore H Under 1 Year H Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
Months Days Hours Min. June 4, 1914 5. Social Security Number 6. Sex 9. Birthplaca (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2DF Yrs. 220-07-1729 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 6013 Hunt Ridge Road 21210 238 IISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (X)No If Yes, Giva Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. d be filed within 72 hours after dental Hygere.

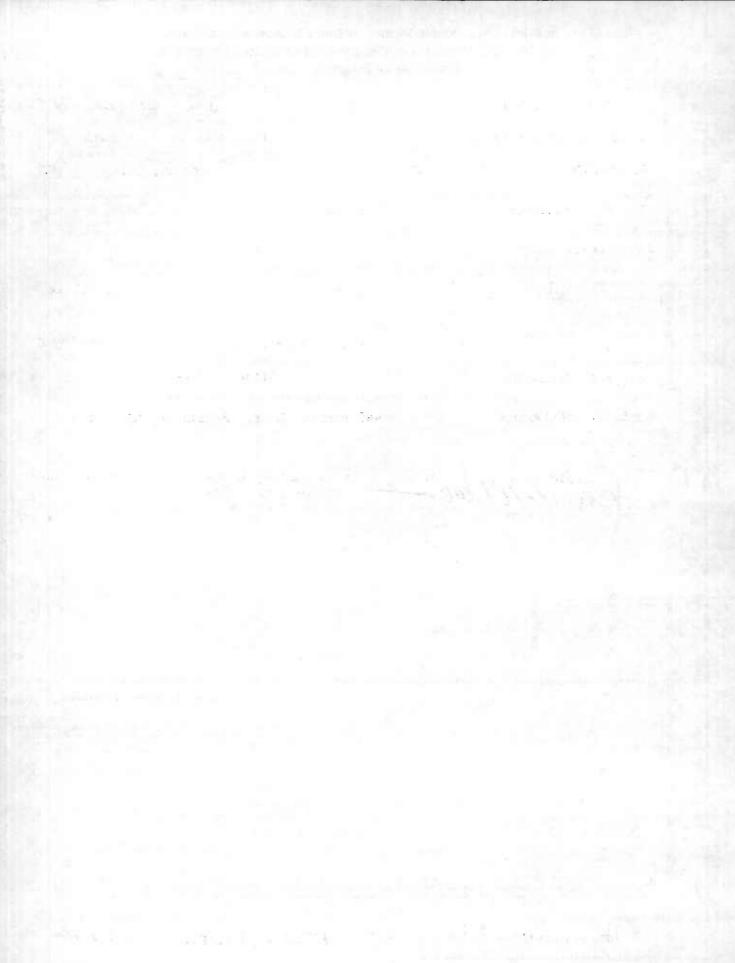
sed other than "netural", or flem
o event, the Medical Examiner. Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes 2 (X) No Specify: Specify. 3 XWidowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry College (1-4or 5+) Elementary/Secondary (0-12) Resident Manager Apartment permit. Pages 1 and 2 should be tile.
Department of Heath and Mental Hyg.
Important: if them 27 is marked other any injury or other transmitted other Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Charles Wiederstrandt, Johnson Adelaide Hall 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill B. Kearns DTR 11 Jack Pine Place Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 XX remation 3 Removal from Stata
4 Donation 5 Other (Specify) 6/15/00 Greenmount Cemetery Baltimore, Maryland uture of Funeral Seption Licenses 22. Name and Addrass of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disea. (, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) encepholopathy DOXIC weeks Examiner Physician/Medical Examiner the death certificate be executed Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, à 24a. Was an autopsy performed? director, page 2 should 24b. Wara autopsy findings available prior to Be Completed complation of cause of death? this certificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical 26. Place of Death (Check only one) Hospitat: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4☐ Nursing Homa 5☐ Rasidence 6 ☑Othar (Specify) 1 Yas 2 No Certification: To Hospice 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Attending 1 Natural 2 Accident 5 Pending investigation or Attandine of the destruction of the destruction of the formal of the 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and dua to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature-emy 1996 of ceptific 29c. License number 29d. Date signed (Month, Day, Year) 125205 1 cm 30. Nama and address of person who completed cause of death (free 23a) (Type, Print) N. Charles St. Balto. Md Z. 20x 6-Bmc 6901 31. Data filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 9 2000 Registrar DHMH 16 Rev 6/95

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A	MEND T	ГЕМ	IS: #7,8 PER ANATO				rtment of F		nd Me			0	193	07
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	/Medi Examii		4e. Facility Name (If not institution, gi	ve street end number	)			4b. City, Tow	n, or Loca	tion of Death	4c. County	of Death	0,100	<i>P'</i> (1)
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	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loc	ation					1	0d. Inside C	the Limite
	Maryle H sho	tor	MD Baltim	ore			imore					'		2∏ No
	or 28a	Oirec	10e. Street and Number				10f. Zip Code				10g. Citizen of V		itry?	
	ath w	ral	449 Lambert Cour					21227			USA			
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Bepartment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat routi be notified at once.	by Funeral Director	11. Men'tel Stetus  1 □ Never Merried 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces 1 Yes 2 N If Yes, Give Year or Dates:	?		res Decedent of F Yes, specify Cubi ☐ Yes 2 ☐ No	lispanic Origi an, Mexicen, Specify:	in? (Specii Puerto Rid	ly Yes or No can, etc.)	Specify	e - Americ ck, White, /: Wh		
2-0	72 ho	eted	15. Decedent's 8 (Specify only highest g	ducation rade completed)	16	(Give k	ent's Usual Occup ind of work done	during most o	of working		16b. Kind of Bu	usiness/Inc	duatry	
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any	should Name		19a. Informant'a Name/Relationship	(Type, Print)	19	b. Mailing	Addresa (Street	and Number	or Rural F	Route Numbe	er, City or Town,	Stete, Zip	Code)	
	and 2 palith n 27 i		Kevin L. McCabe/	son		449	Lambert	Court	Ва	ltimor	e, MD	21227		
Baltimore,	Pages 1 ment of H ent: If iten ury or ott		20e. Method of Disposition  1 Burial 2 Cremetion 3 4 Donation 5 Other (Special Control of Control o		0.000.01	of Dispos ery, crem	ition (Neme of etory or other ple	сө)		Dete	20c. Location -	City or To	wn, State	
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	/Medical Examiner		Immediate Cause (Fine) disease or condition resulting in death)	a. S	epsis	Syni	drome						24	hrs
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	d ansit	Examiner	Sequentially list conditions	b	Due to (or as		bD C	MF					104	
Ő,	cate be executed physician and the burial-transit	Exe	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	Σ.	EVEKE	Dei							48h	rs
8760,	cate b	dical	that initiated eventa resulting In death) Last	Ç	Due to (or es a	consequ	ence of):							
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ă	death d for 1	iclai	Part II. Other eignificant conditione	contributing to death t	out not resulting	in the un	deriving cause ob	en in Part I		23h Did	tobacco uee co	ntribute to	the cause	of death?
Division of Vital Records, P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use es		Gastre ,								Yee 2□ No	3 Prol		Unknown
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ta	en: Tificat tificat tor, pa	Be C	25. Was cese referred to medical					26. Place o	of Death /	Check only o		1	1 100 2	140
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0	ng Phys ter this meral di		27. Menner of Death 1 Natural 5 □ Pending	28a. Date of Inju	ury 28b	. Time of Injury	28c. Injur Wor	y et rk?	28	d. Describe l	how injury occur	red		
Sio	leath.	cati	2 Accident Investigation 3 Sulcide 6 Could not	20				Yea 2□N						
<u>N</u>	To the Mospital or Attending Physicien: The Is within 24 hours effect eath.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification:	4 Homicide determined	28e. Place of In	jury - At home, tc. (Specify)	farm, stre	et, fectory, office		28f. Location (Street end Number or Rural Route Number, City or Town, Stete)					iber,
	the Hosp in 24 hou the Funer ipletely fil	edical	29a. Certifier (Check only one)  Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner (Check only one)  Medicat Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated.									enner es s and due to	eted. the ceuse(s	3)
	of the second	Σ	29b. Signature and title of certified	m			29c. Licens				29d. Date signe			
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			30. Name and address of person who				rint)	Minus						
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DHI	MH 16 Rev 6/9	5	1 = 4			-	The same							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9308 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth -Month **Physician** 0 2000 /Medical 4c. County of Dea 4b. City, Town, or Location of Death Facility Nama (If not institution, give street and number) Examiner ford enter der i Year Ursing & Keho more 1en & Keha o, Ce If Under 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min. Months Days 1 M 2 F Hours 7616 241-24-Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 ia marked other than "natural", or Itama 23a or 28a-f ahow any Injury or other traumetic avant, the Medical Examiner must be notified at Maryland 1 OYes 2 No **Funeral Director** 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zio Code 9 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No. If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 14. Race -11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Affin D Specify Completed by 3 ₩idowed 4 Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 501 nrna daughter 19b. Mailing Address/(Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e, Informant's Name/Relationship (Type, Print) n 2/35 Per 20b. Place of Disposition (Name of .2/223 10. 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State Mem. far 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Façi Josep uneral 222 W. North Ave. ie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examine ettending physician and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DUSPHAG-1A þ 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy performed? Completed ASPIRATION PREUMONIA certificate hes 1 Yes 2 No 1 Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: \ Nursing Home 5 Residence 6 Other (Specify) apital or Attanding Physic hours after death. neral Director: After this co y filled in by the funeral dire edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 WNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled To the Hospita To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

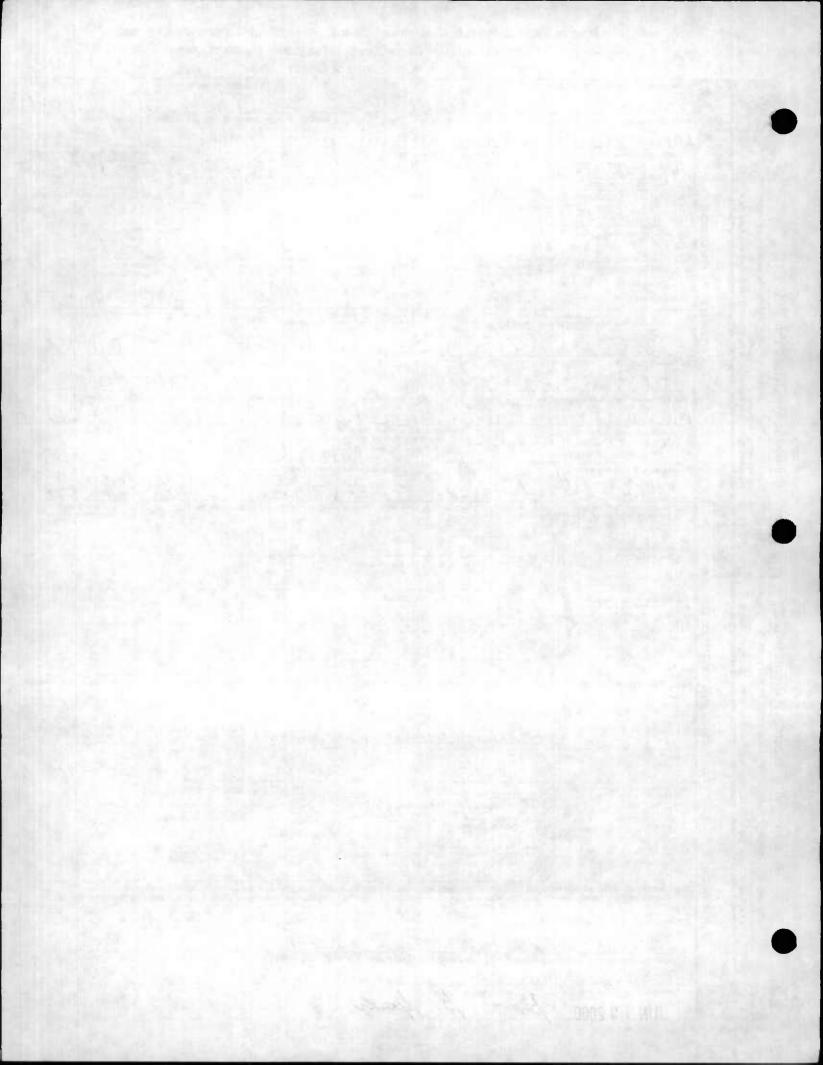
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 16 muncha c reuminely 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northern Parkwai

**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Day, Year)

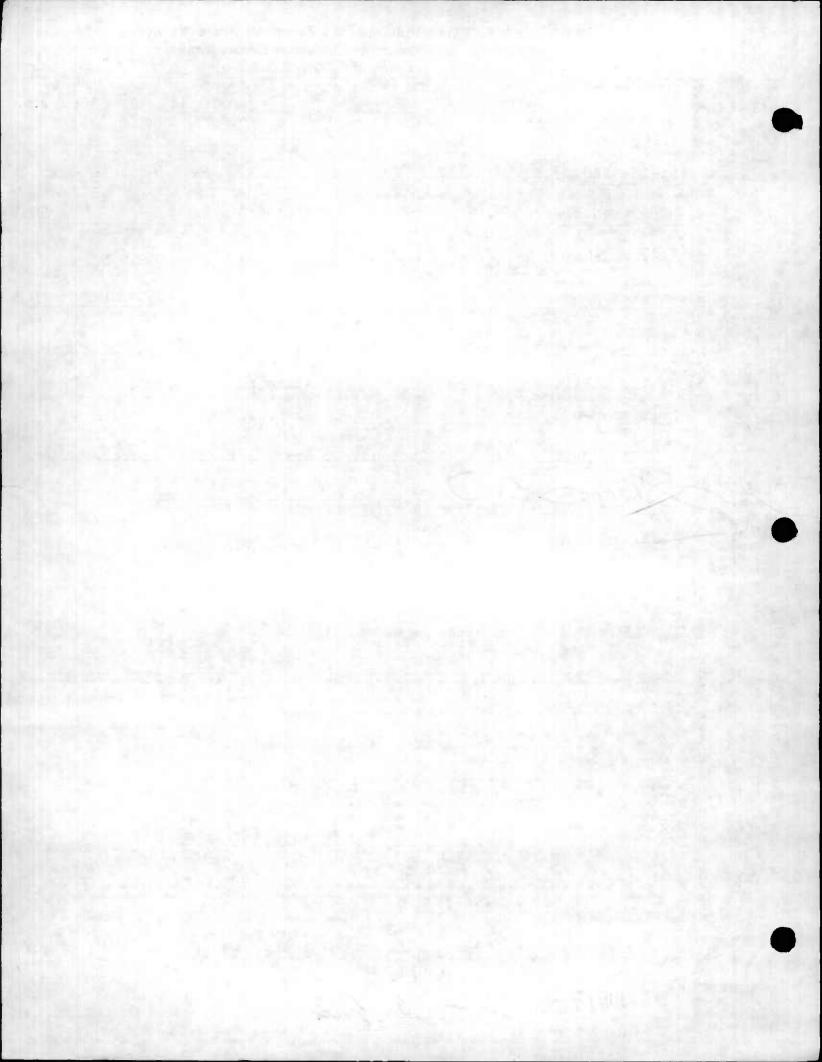
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

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, ololow	Decedent's Name (First, Middle, Last)									2. Data of De Month	ath Day	Year	3. Time of	Death		
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=	10a. State	10b. County	/		10	c. City, Town	or Location	ion					1	10d. Inside C	Ity Limits	
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Box 68760. Division of Vital Records, P.O. Hospital

Medical Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, ferm, streat, factory, office building, atc. (Specify) 4 Homleide 12 Certifying Phyaician: To the best of my knowledge, deeth occurred et the tima, deta and place, and dua to the ceuse(s) end manner as stated. 29a. Cartifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceusa(s)

23a) (Type, Print)

29c. License number

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29d. Data signéd (Month, Day, Year)

end mennar stated.

32. Ragistrat's Signature

State Registrar 29b. Signatura and title of certifian

31. Dete filed (Month, Day, Year)
JUN 1 9

30. Nama and addrass of person who completed causa of death (Ital

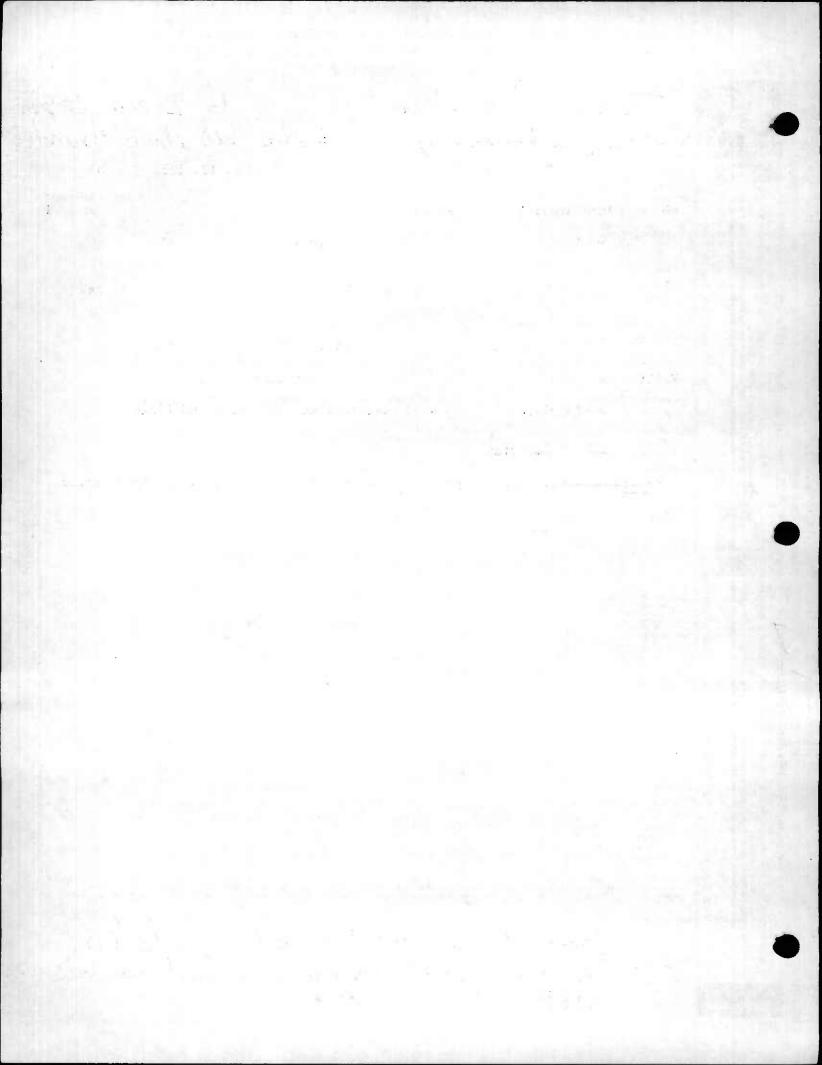
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**DHMH 16 Ray 6/95** 

within 24 hours aft To the Funeral Di completaly filled in

To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** ARIC ROBERTSON 2000 Medical 4b\_City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner and a stown 7. Age (In yrs. lest birthday).

Yrs. If Under 24 Hrs. If Under 1 Yeer 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 6. Sex **Funeral** 214-40-509 Usuel Residence of Decedent 10M 20F Months Deys Hours and Director a the Marylend 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Yes 2□No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 lenue Funeral d 12. Was Decedent Ever In U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian. 11. Meritel Status Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify à 3 ☐ Widowed 4 ☐ Divorced 2 Year or Detes: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College/(1-4or 5+) Pages 1 end 2 should be filed within nent of Health end Mental Hyglene. Int: If item 27 is marked other than Iry or other traumatic event, tre. It 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be 19a. Informent's Neme/Reletionship (Type, Print) (Caretaker) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) unit 901 to. N.d. 2/2/5 20b. Plece of Disposition (Neme of cemetery, cremetory or other) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from Stete permit. Page Department of Important: If eny injury or once. 4 □ Donetion 5 □ Other (Specify) Mem. Par 21. Signatore of Funeral Service/Ocensee 22. Name end Address of Fecility Hom Joseph tunera WiNorth Ave. Balto. 23e. Pert1/Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feither. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical ROSEPSI Examiner Due to (or as a consequence of) Physician/Medical Examiner AR BROVA The law requires that the death certificate be executed nding physician and use as the bunal-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of) Box 68760. thet initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown Records. à 24b. Were eutopsy findings available prior to completion of ceuse of death? Be Completed 24a. Was an autoosy page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Division of Vital Hospital or Attanding Physician: 24 hours after deeth. Funeral Director: After this certifica stalf filled in by the funeral director. 25. Wes case referred to medical axeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatienf 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending Investigation Injury 1 Yes 2 No 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

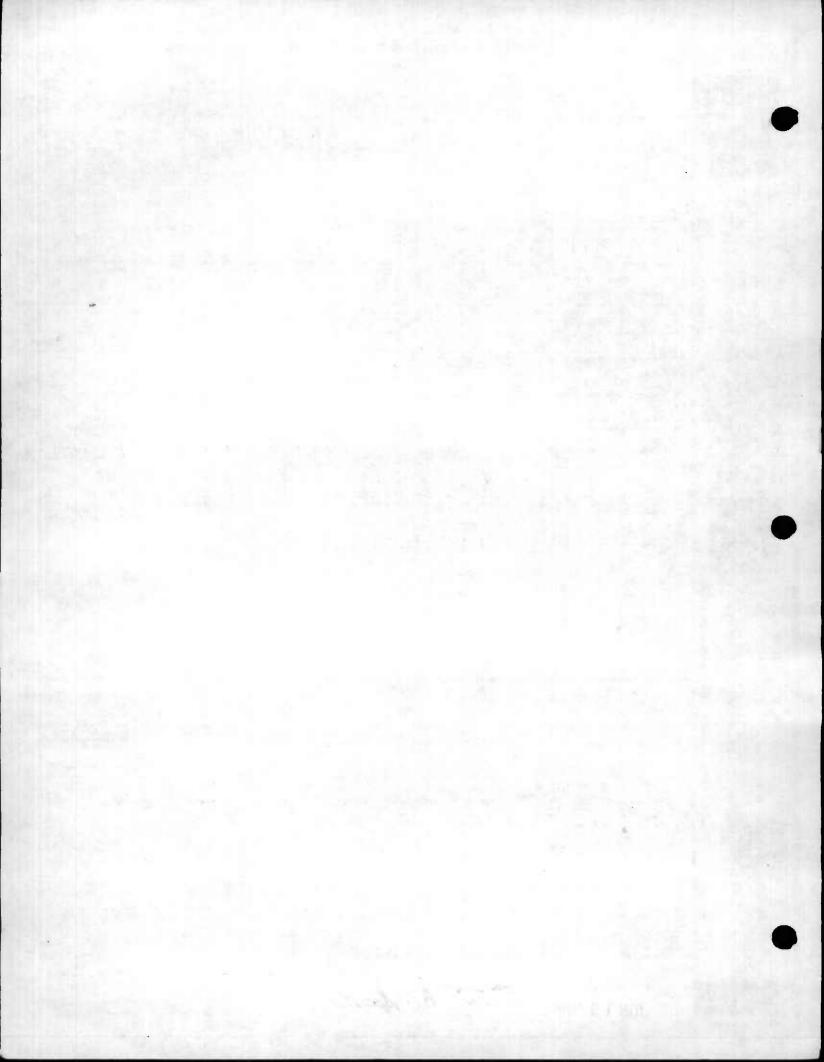
| Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 21133 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD COURT RD. RANDALLSTOWN ND DR. EDWARD 31. Dete filed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar

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JUN 1 9



amend it	State of Maryland / Department of Health and More 19b per infor. G784 6/23/00 yg Certificate of Death	ental Hygiene 00	19312
Physician /Medical	1. Decedant's Nama (First, Middla, Last)  Nathaniel D. Rice	2. Data of Daath Month Day Year June 14 2000	3. Tima of Death 5.00 P17
Examiner Funeral Director	4b. City, Town, or Local Security Number  6. Sax  7. Aga In yrs, last birthdey)  When the property of Decedent  1 In M 2 In F Supering Security Number Securit	etion of Deeth 4c. County of Death  10 C 8. Deta of Birth 9. Birth	A place (State or Foreign
ath with the Maryl a 23s or 28s-f sho marke notified a rail Director	10b. County  NA  NOTISTOUN  10c. City, Town or Location  NOTISTOUN  10f. Zip Code  19401  11. Maritai Status  12. Was Decedent Ever in U,S. Armed Forcas?  13. Wes Dacedant of Hispanic Origin? (Spanif Yas, specify Cuban, Maxicen, Puerto Forcas?)	10g. Citizen of Whet Cour	en indien,
n 72 n n 72	1 Nevar Married   2 Married   1 Nevar No   1 Yas 2 No	Shedhi i Ca.  16b. Kind of Business/in	n American
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more, had ages 1 end ent of Health it; if them 27 y or other tu	Mr. Donald F. Rice  20a. Method of Disposition  1 Burial 2 Dicremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Nama of cematary, cramatory or other place)  Green mount Crematory	pata 200c. Location City or To	19401
100	21. Signature of Fundral Service (Icenses)  22. Name and Address of Facility  JOSEPH L. RUSS  2772 W. North A  23a. Part I, tinter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or shoot, or heart failure. List only one cause on each line.	Funeral Home, ve. Batto, Md	2/2/6 Approximate interval Betwaen
Physician /Medical Examiner	Immadiete Causa (Final disaasa or condition resulting in death)  A Cute repair four four four four four four four fou		Onsat and Deeth  Meeks  Types
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Direction of the Hospital or the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Hospital	29a. Cartifiar (Check only (Ch	City or Town, Stata)  Indicate the cause(s) end mannar as sided the time, date and plece, end due to	ated.
within 2 vo the compla	one) and manner stated.  29c. Licansa number	29d. Data signad (Month,	
	M Rabelle Mac greger 470 D13657	June 1	5,2000
	10. Name and addrass of parson who complated cause of death (Ifam 23a) (Type, Print)  M. T. B. A. B. E. L. E. M. D. C. R. F. G. R. L.	EET, BALTIMORE)	07021211
State S Registrar	11. Data filed (Month, Day, Year)  32. Ragistrer's Signatura  4. Apockly		

State of Maryland / Department of Health and Mental Hygiene

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Registrar

DHMH 16 Rev 6/95

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Piease Type or Print in Biack indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 955pm Month **Physician** JUNE ,2000 Willie Richardson /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
| If Under 24 Hrs. | 8. [ Stella Maris Mercy If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2□ F 72 Director 245-40-3757 Usual Residence of Deceden 06 N.C 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylai Department of Heelth and Mental Hydiene. Important: If Item 27 is marked other than "natural", or Itema 23s or 28s-1 show why highey or other treumatic avant, the Maddosl Examinal that another a notified as page. Director XYes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 Funeral 1824 Thomas Ave U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XIXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Chessie Railroad Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Trackman System 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Enoch Richardson Pattie West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2014 Alto Vista Ave, Baltimore Md

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dete 20c. Location - City or To Doreen Garrett-Niece 21207 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removel from Stele
4 Donation 5 Other (Specify) Woodlawn Cemetery 6/17/00 Baltimore Co, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore Md 21215 Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of). buriel-trensit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Onknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 | Yes 2 | No certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien:
Within 24 hours after death.
To the Funeral Director: After this certifical completely filled in by the funeral director; 8 25. Was case referred to medical 26. Placa of Deeth (Check only one) STELLA MARIS AT MERO) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS pic E Hospitel: 1 npatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 10 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide TCertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number Del Ihm

State Registrar

DHMH 16 Rev 6/95

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

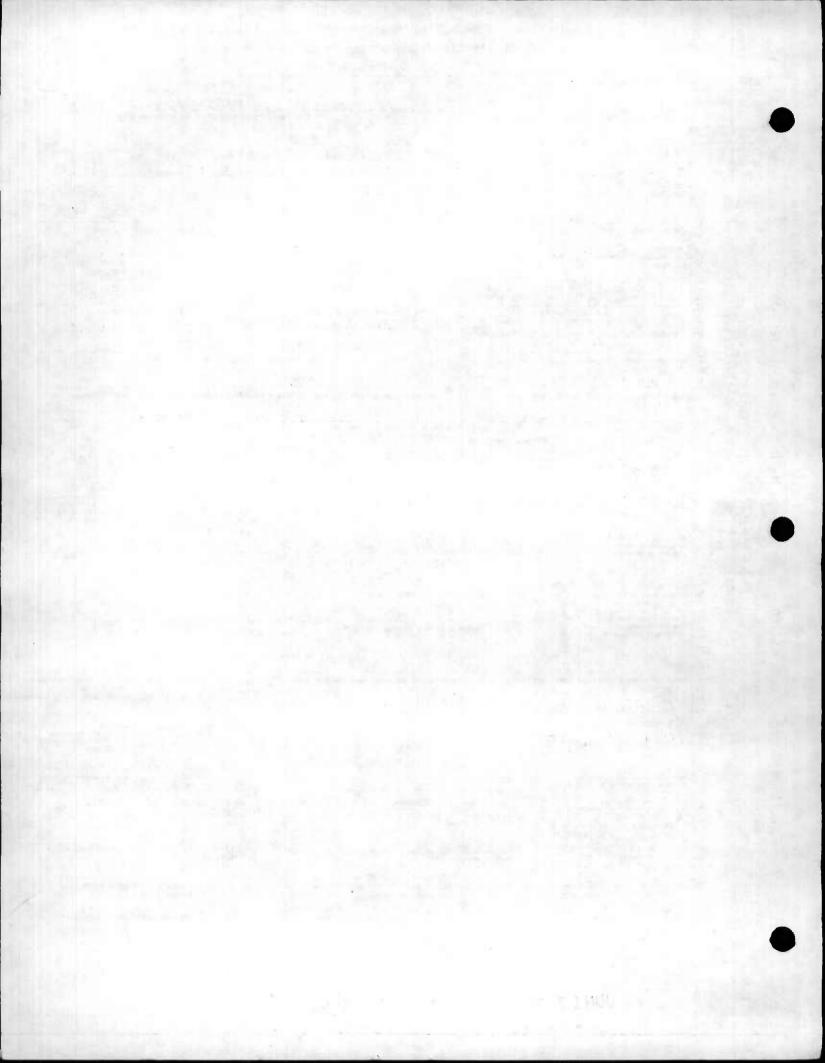
RISEBERG

JUN 1 7 2000

31. Date filed (Month, Day, Year)

ORIGINAL

BALTIMORE MD 21202



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3 Time of Death Month **Physician** 30 5, 2000 4c. County of Paath June /Medical Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Death Genesis Elder 5. Social Security Number 6. Se Manor Care timore aton 7. Aga (In yrs. last birthday)
Yrs. If Undar 24 Hrs. 8. Data of Birth
Month, Dey, Year)
JUNE 12, 1915
South If Undar 1 Yaar ge (State or Foreign 250-18-2665 Usual Rasidance of Decedant Days Months 1 X M 2□ F Hours 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland 1 XYas 2 No Director mor 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? C 21 22 Funeral ndSon 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian, Biack, Whita, atc. 1 ☐ Nevar Married 2 Married 1 XYas 2 No If Yas, Giva Year or Datas: 1□ Yas 2 No Specify: ρ 3 ☐ Widowed 4 ☐ Divorced ac Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) ec 0 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Be P ZOr noma 19a. Informent's Name/Ralationship (Type, Print) Wife 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) s. ratty 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Buriai 2 Cramation 3 □Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Son ore. 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Joseph 2222 V 15 Aug WiNorth Entar tha disass, or complications that caused tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, or heart fullure. List only one ceuse on each line. Approximata Interval Between Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) SEPSIS I WEEK Dua to (or as a consequance of): by Physician/Medical Examiner PNEYMONIA IWEEK Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseese or Injury that initiated avents resulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No CEREBROVASCULAR ACCIORNI Completed 24a. Was an autopsy 24b. Wara autopsy findings available prior to PERIPHERAL VASCYLAR DISEASE performed' compiation of causa of death? RHEYMATOID ARTHRITIS 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Wes casa rafarred to medical axaminar? Be 28. Placa of Death (Check only one) Hospitai: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Deta of Injury (Month, Day Year) 28b. Tima of 27. Menner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Panding invastigation 1 Matural 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 | Homicida tire Certifying Physician: To the best of my knowledga, daath occurred at tha tima, dete and place, and dua to tha cause(s) end mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and mannar stated. Medical (Check only one)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

**Funeral** 

**Director** 

or 28a-f show

items 23a

permit. Peges 1 and 2 should be filed within 72 hours effer a Department of Health and Mentel Hygiene. Important: If item 27 is merked other than "natural", or item any Injury or other traumatic event, the Manter 2000.

**Physician** /Medical

Examiner

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traumatic event, the Medical Examiner must be nutflied at

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To the Hospital or Atterwithin 24 hours efter der To the Funeral Director completely filled in by the

State Registrar 31. Data filed (Month, Day, Year)
JUN 1 9 2000

C.V. CYRIAC. M.D

29b. Signatura and titla of certifiar

Equae Mo

BIO9 RITCHIE WWY, PASADENA, MD 21122. 32. Registrar's Signatura

ATTENDING

30. Name end addrass of person who complated causa of death (Item 23a) (Type, Print)

DOCTOR

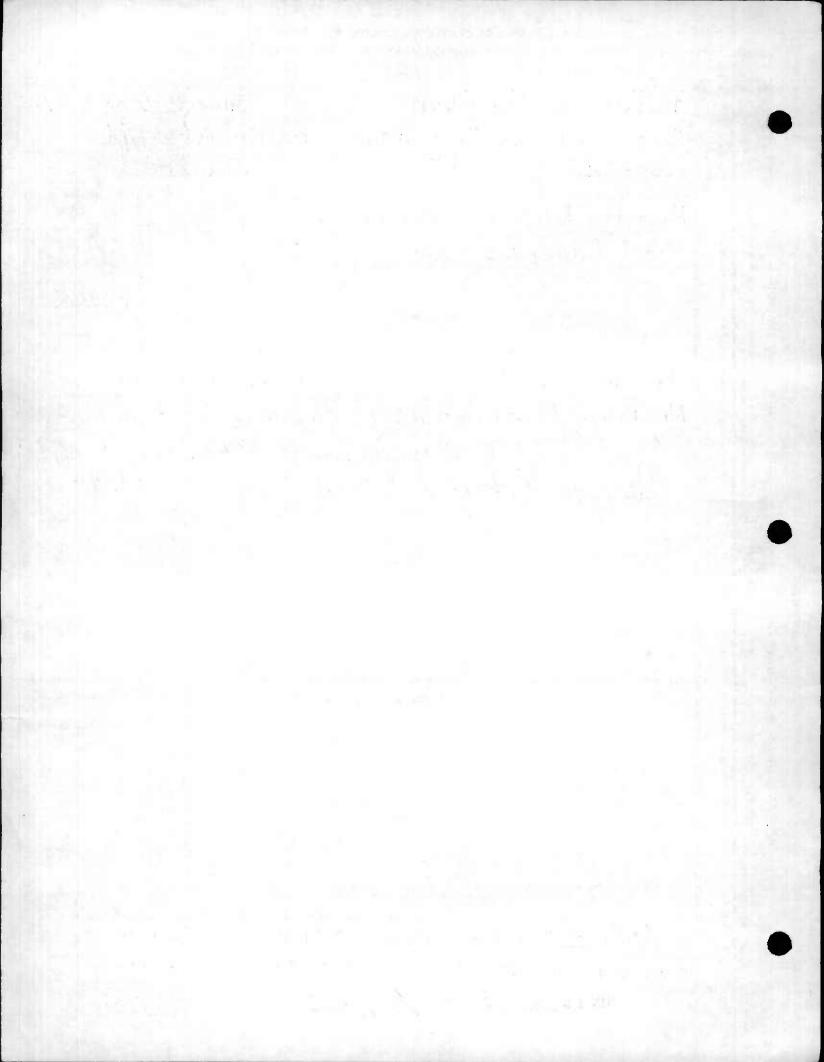
29c. Licansa number

D21684

29d. Data signed (Month, Dey, Year)

JUNE 16, 2000

DHMH 16 Rev 6/95



### Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Vear **Physician** 530 Kathleen Slenbaker 12000 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not Institution, give street end number) 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Houra Min. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) 6. Sex **Funeral** Days Months Yrs. Director 74 213-20-9188 Jan. 12,1926 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show YNYYes 2□No Director Maryland N/A Baltimore 28a-10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 238 Funeral 6007 Glenoak Avenue 21214 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notit Yes, specify Cuban, Mexican, Puerto Rican, etc.) pemit. Pages 1 and 2 should be filed within 72 hours aftar. Department of Health and Mental Hygians. Important: If itsm 27 is marked other than "naturel", or healeny injury or other traumatic event. 1 ☐ Yes 2/2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Clarence R. Mc Kenny Annie H. O'Bryan 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pamela Blake Daughter 3318 Paine Street Baltimore, Maryland 21211 20b. Place of Disposition (Name of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 6/19/00 Pikesville, Maryland 21. Signature of Funeral Service Licensi 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or compositives that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Shickby disease or condition resulting in death) Examiner Distance The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760, 1 hysena Physician/Medical the Due to (or as a consequenca of): dompine for use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings availabla prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 3-NO 1 Yes 2 No of Vital Physicien: 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No edical Certification: To 1 Umpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation s after de-el Director: Aftr 1 Naturef 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide within 24 hours a To the Funerel C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the

State Registrar 29b. Signeture and title of certifier

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Randlph

tress of person who completed cause of death (Item 23a) (Type, Print)

33

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29c. License number

STREET

29d. Date signed (Month, Dey, Year)

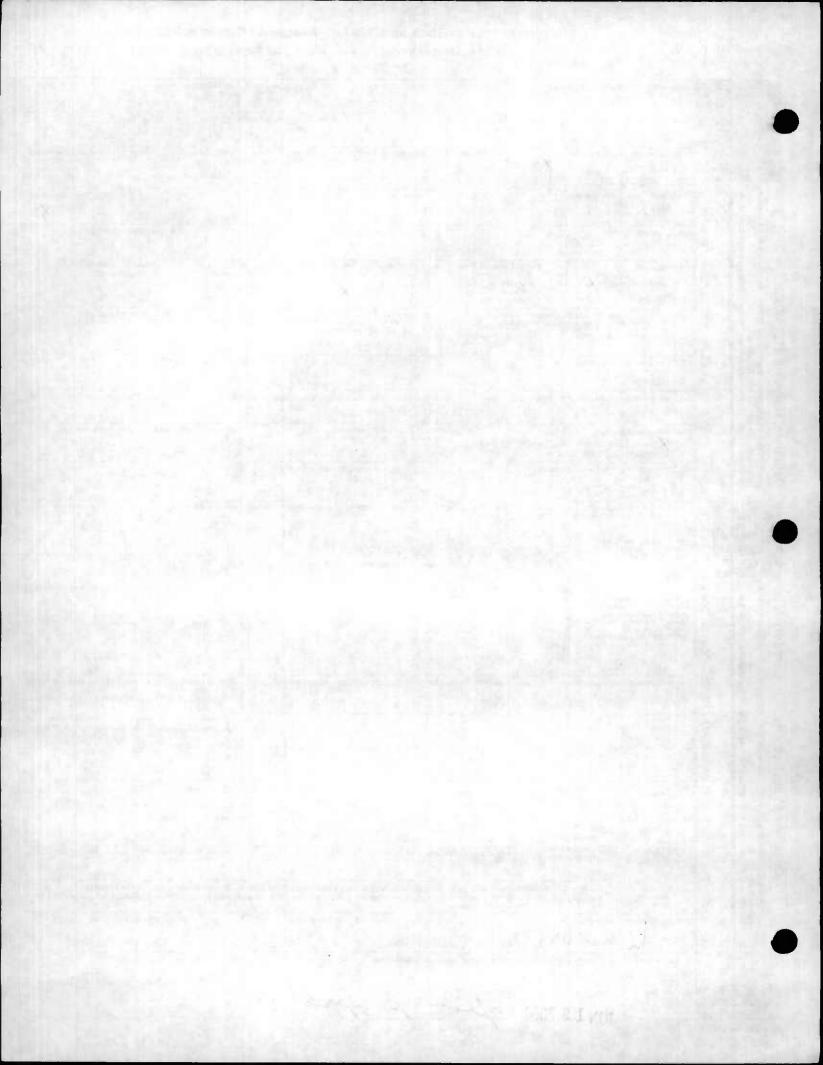
**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene

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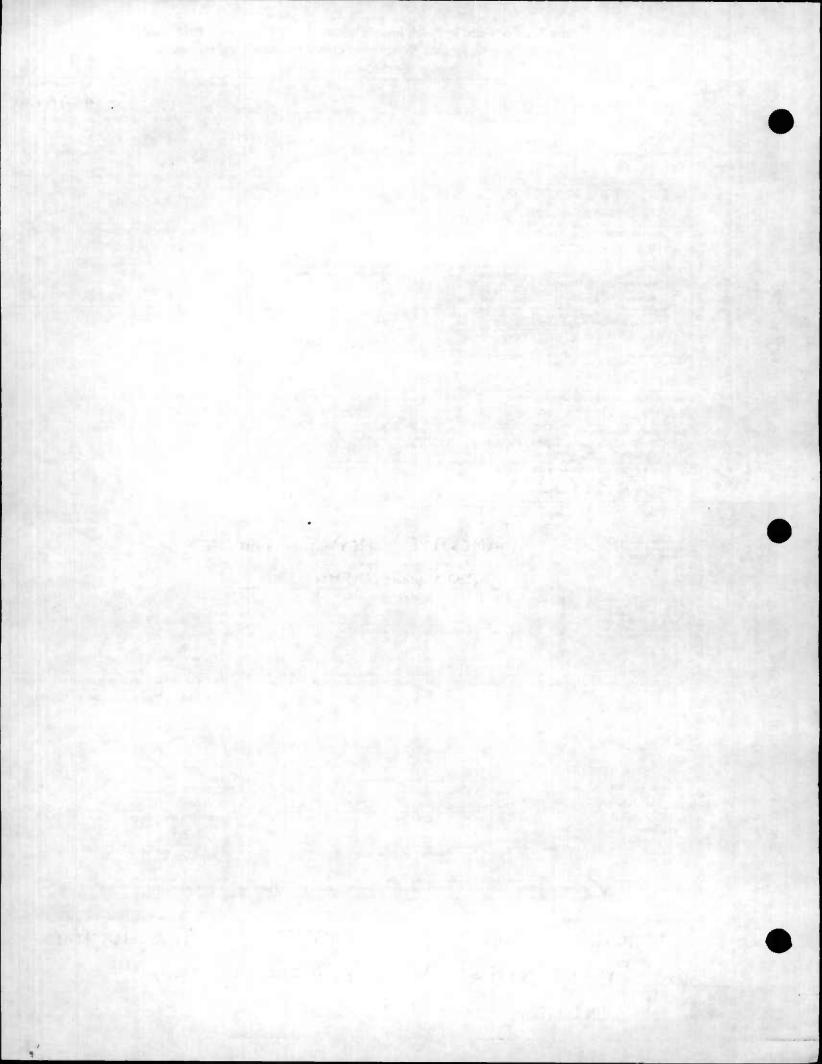
# Shiflett, Rendelph

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DHMH 16 Rev 6/95

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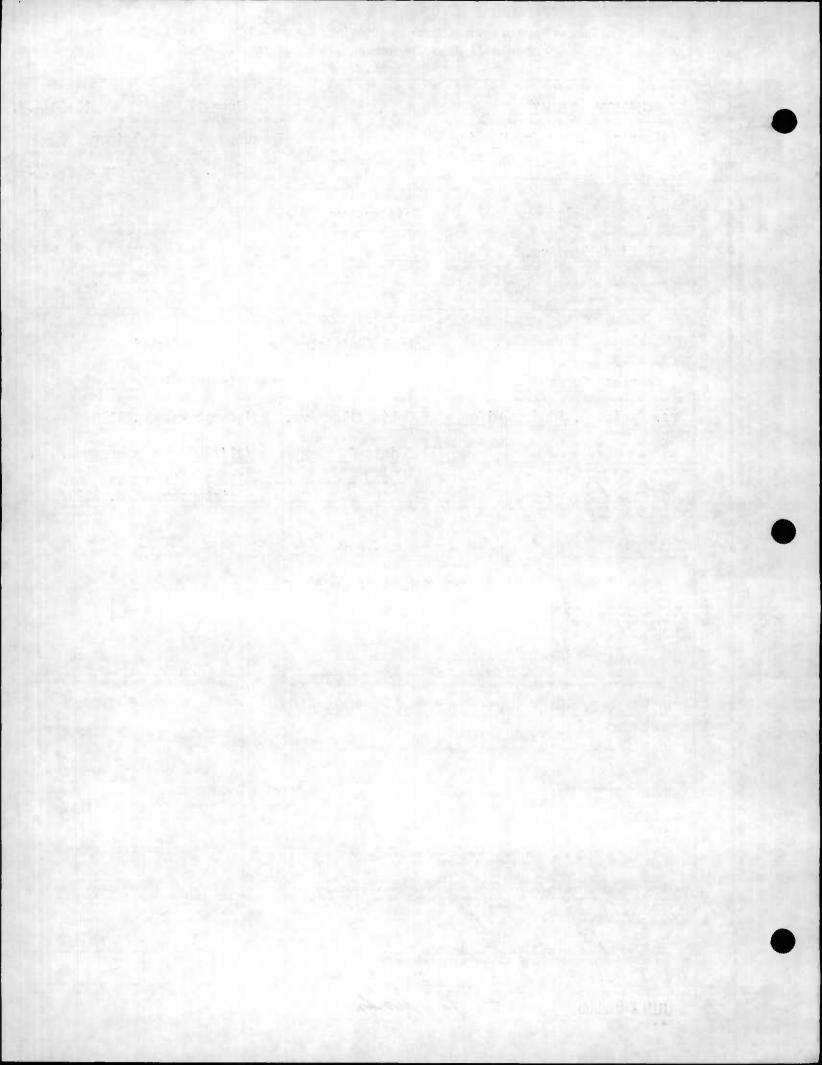
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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d of	10e. Street and Number 10f. Zip Code						10g. Citizen of V	Whet Country?			
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P	15. Decedent's E		16a De	cedent's Usuel Occ	unation		16b. Kind of Br	usiness/Industry			
det	(Specify only highest gi	ade completed)	(G	ive kind of work do	ne during most d	of working					
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0 00	Charles Sund				Athe		ricvitak				
2	19e. Informent's Name/Reletionship	-	19b. Me	eiling Address (Stre		or Rural Route Numi					
	Mrs. Janice C. S					Reisters					
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	21. Signature of Funerel Service Lice	nsee		22. Name end Add	ar money	ME 11824	Reister	stown Road			
	Janos &	une .				Keist		Md. 21136			
Je	23e. Jent: Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,  Approximate Intervel Betw Onset and D  Immediate Ceuse (Finel disease or condition resulting in deeth)  But A Cevebro Heworhage  Due to (or es e consequence of):  The work of the more hage  Due to (or es e consequence of):										
Examiner		b. 100	Oue to (or as e con:	cy to p	euim			1 genis			
	Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						0			
ın/Medicai Examir	resulting in deeth) Last	d	ue to (or as e cons	sequence or).		100					
Physicia	Part II. Other significant conditions	contributing to death but	not resulting in the	e underlying cause	given in Pert I.	23b. Did	l tobacco use co	ntributa to the cause of dea			
by Ph	chronic l	-yougho	cytic	Leuke	nia	10	Yes 2000	3 Probably 4 Unknown			
Completed b		V					s an autopsy ormed?	24b. Were autopsy finding evelteble prior to completion of cause of deeth?			
E						1	Yes 2 No	1 ☐ Yes 2 ☐ No			
	25. Wes case referred to medical				26 Place	of Deeth (Check only					
o Be	examiner?	Hospitel:	t o∏ EB/Outon	tions all DOA	Other			ner (Specify) Hospic			
-	27. Menner of Death  1 Netural 5 Pending 2 Accident Investigation	27. Menner of Death  1 Selection of Legislation   2 Selection of Legislation   2 Selection of Legislation   2 Selection of Legislation   2 Selection of Legislation   2 Selection of Legislation   2 Selection of Legislation   2 Selection of Legislation   2 Selection of Legislation   2 Selection of Legislation   2 Selection   2 Selection of Legislation   2 Selection of Legislation   2 Selection of Legislation   2 Selection of Legislation   2 Selection   2 Selecti									
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edical C		hystclan: To the best of miner: On the basis of e end menner stet	examinetion end/or					annar as stated. and due to the cause(s)			
M	295. Signature and title of certifier	29d. Date signe	ed (Month, Dey, Year)								
	1 H Am	June 1	7, 2000								
	30. Neme end eddress of person who	completed cause of de	76		Sales .	St. Ba	lto. mo	40512 1			
State	31. Dete filed (Month, Day, Year)	32. Registre		1 .				,			
strar	.HIN 1 9 2000	General	D A	ports							



Records, P.O. Box 68760. Division of Vital

Examiner The law requires that the death certificate be executed burial-transi and attending physician for use es the burial the page 2 s hes certificate this To the Hospital or Attending PI within 24 hours effer deeth.
To the Funeral Director: After the completely filled in by the funera Aftert

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be P

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Heelih and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at once.

**Physician** 

/Medical

Examiner

Physician/Medical

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Certification:

Medicai

Baltimore, Maryland 21215-0020

CHRUNC RENDE HYPEZTENS. ... 25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ HomicIde 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signeture and title of cert 29c. License number 29d. Dete signed (Month, Dey, Year)

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JUNE 14, 2000

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BALTIMORE, MI)

CHARLES O DOJOVAJ TI 31. Dete filed (Month, Dey, Yeer)

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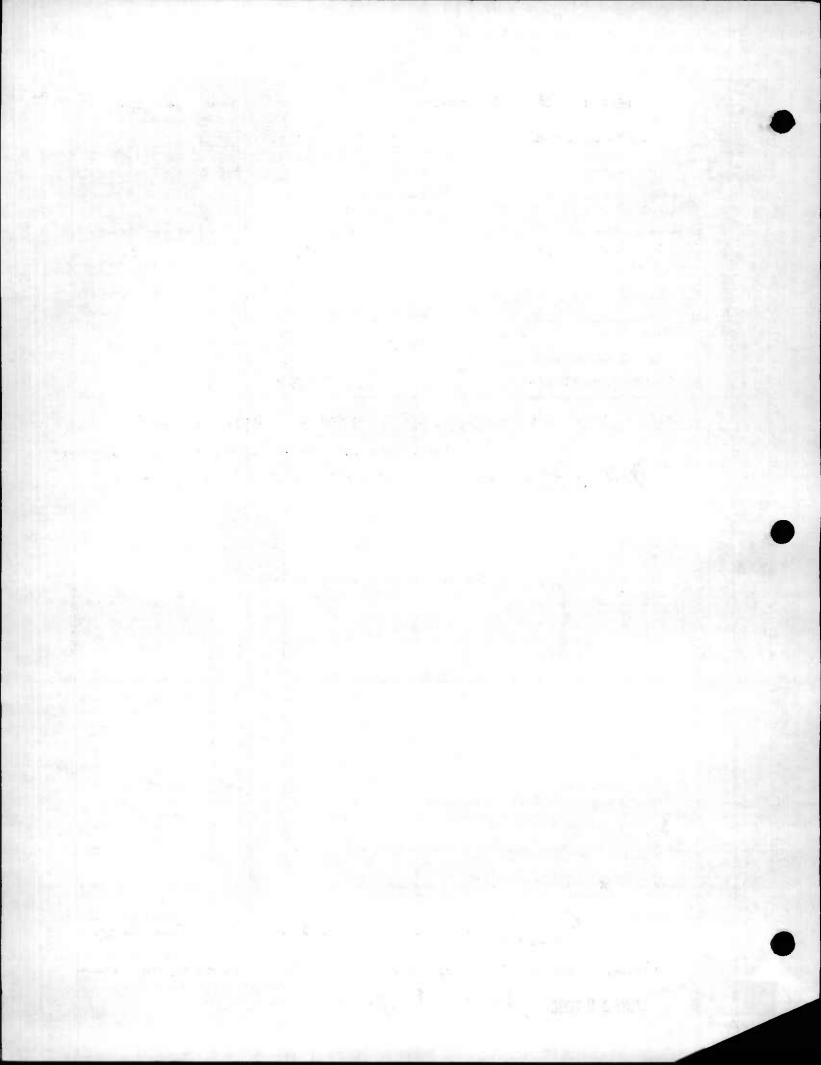
32. Registrer's Signeture

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

GIGT N. CHARLES ST

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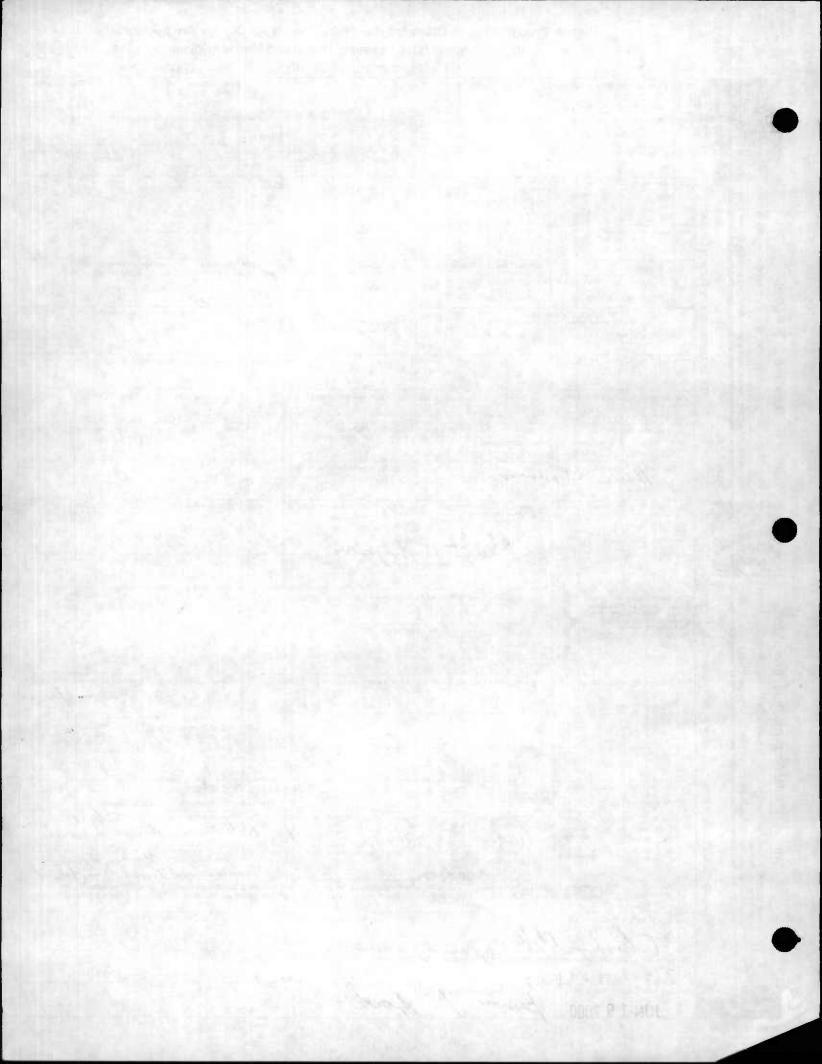
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

19321.

		1. Decedent's Name (First, Middle, Last)  2. Date of Death  3											4 D 15			
	Physician	_	. Decedent's Name	(First, Middle, i	Last)							2. Date of Dea Month	Day	Year	3. Time o	or Death
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	Examiner	4	a Fecility Nama (If I	not institution, g	give street and n	umber)				4b. City, To	wn, or Lo	ocation of Death	4c. County	of Death		
44	Examine	н	Semi	nary A	venue @	Jam	ieson	Road		т	owsc	n	Ral t	imor	~	
_	F	5	. Social Security Nur	-	. Sex	-	e (In yrs. las			1						or Foreign
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Maryland	and s		9a. Informant's Nam					19b. Mailir	ng Address (Stre	eet and Numbe	or or Run	al Route Numbe	r, City or Town,	State, Zi	p Code)	
N.			Susan M.	Smith	(Wife	)		8238	Jeffer	s Circl	10 5	Toward	Marria	ad 21	20%	
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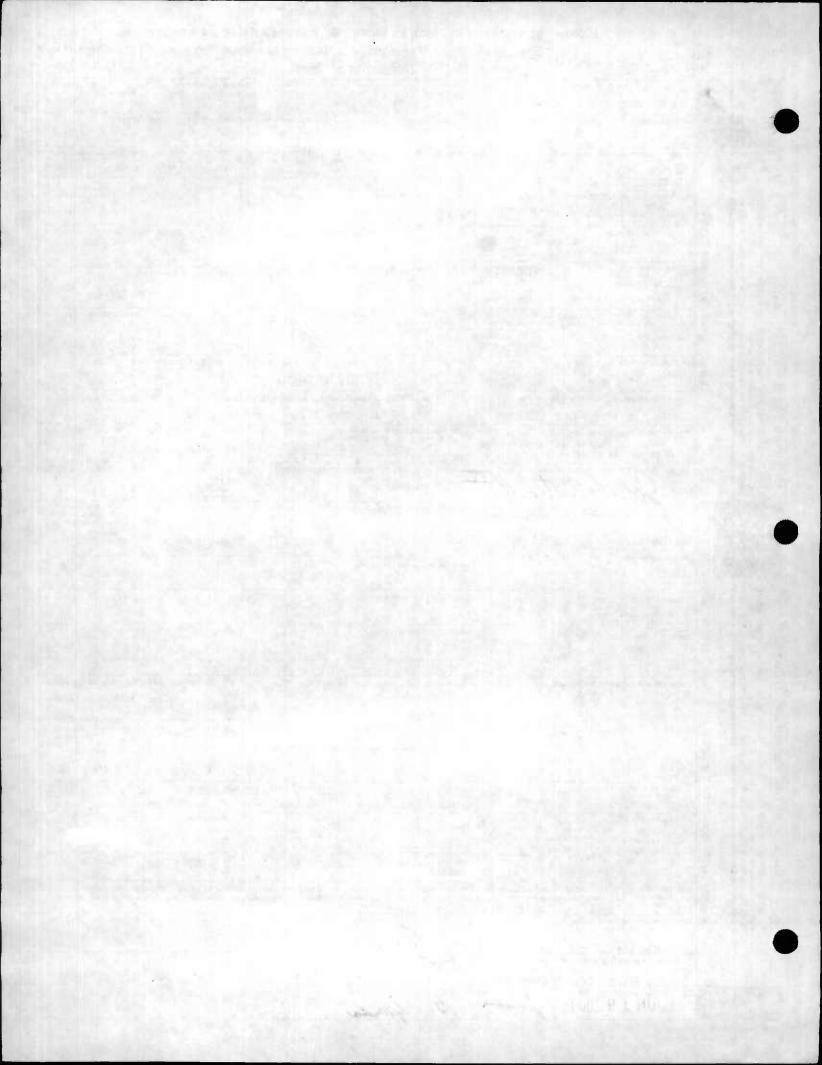
00-3315-025 Please Type or Print In Black Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AFR #23 FARF 1, 27, 28A-F FER MED Certificate of Death UNK 00-154 9322 AS1 mnmr 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nelson Martin Stauffer JUNE 14 2000 1730 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAPIDUM LAPIDUM LANDING SUSOUEHANNA STATE PARK HARFORD 5. Social Security Number 6. Sex 11XM 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 31 209-62-6695 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Lancaster Ephrata 1 Yes 2 No Pennsylvania Directo "natural", or items 23s or 28s-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 209 Hahnstown Rd. 17522 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry P And Mental Hygen

7 is marked of summer Elementary/Secondary (0-12) College (1-4or 5+) travel stop maintenance worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David S. Stauffer Lydia Martin Pages 1 and 2 should 19a. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health I Ephrata, PA 17522 209 Hahnstown Rd. David S. Stauffer/father altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Department of I 1 XBurial 2 Cremation 3 Removal from State Stauffer Pike Mennoniteem. 6/17/00 Earl Township, PA ŏ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 21. Signeture of Funeral Service License 6500 York Rd Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** DROWNING /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) USB 10 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. signed by I 1 Yes 2 No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were autopsy findings evailable prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed Sec WYes 2□No 1 Yes 2□ No Attending Physician: 25. Was case referred to medicet axaminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To Other: 4☐ Nursing Home 5☐ Residence 6 ☐Other (Specify) SCENE 1X Yes 2 □ No this funeral 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred SUBJECT WAS IN 27. Manner of Death P Certification: 28c. Injury at Work? After (Month, D 5 Pending investigation 5:58 1 Natural 1 ☐ Yes 2X No SMALL BOAT WHICH SANK death. 2 Accident within 24 hours after death To the Funeral Director: / completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

RIVER 28f. Location (Street and Number of Bural Route Number City or Town, State) SUSJEHANNA RIVER, 4 Homicide 6 HARFORD CO. MARYLAND Hospital 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stelled. 29a. Certifier edicai (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E JUNE 15,2000 30. Name and address of person who completed ceuse of death (Item 234) (Type, Print) Stephen S.
31. Dete filed (Month, Day, Year)
JUN 19 2000 Radentz 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9323. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Yeer **Physician** RUTH STEIN JUNE 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Deys 1□ M 21 F Yrs. 189-22-1347 Director APR.10,1931 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo MD BALTIMORE OWINGS MILLS 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10316 CASCADE RUN COURT 21117 U.S.A. 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give X Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) par 1 and 2 ahould be filed within 7; of Health and Mental Hygiene. If Item 27 is marked other than "nu is other traumatic event, the Media Elementery/Secondary (0-12) College (1-4or 5+) PROPRIETOR HEARING HEALTH CARE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be MAX COHEN SARAH ROBBINS 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) HARVEY B. STEIN / HUSBAND 10316 CASCADE RUN COURT - OWINGS MILLS, MD 21117 Baltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State T 1 ☑ Burial 2 ☐ Cremetion 3 ☑ Removel from State
4 ☐ Donetion 5 ☐ Other (Specify) KING DAVID MEMORIAL GARDENS 6/16/00 FALLS CHURCH, VA 21. Signature of Fungful Solvice Licens 22. Neme end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 def, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, List only one cause on each line. Approximete Interval Between Onset end Death 23a. Pert1. Enter the des **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical END STAGE CARDIO MYUPATHY Examiner Examiner DISEASE ORCMARY ARTERY the bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Box 68760, ITABETES Physician/Medical Due to (or es e consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wars autopsy findings eveilable prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medicel examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 0 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Neturel Division or Attending 5 Pending investigation s after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled In by 4 Homicide Hospital 24 hours a Funeral D Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) and menner as stated 2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end menner stated. 29e. Certifier completely (Check only one) To the Vithin 2 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifie 29c. License number

Registrar DHMH 16 Rev 6/95

State

**ORIGINAL** 

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4231

Northwoods Trail Hampsteal MD

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

GOEDERE

32. Registrer's Signeture

REBECCA

31. Dete filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 9324 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death 2000 Month Day **Physician** 5:50pm RANDOLPH TAYLOR, SR. June /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Rosedale Franklin Square Hospital Center If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 ₩ 2 □ F Director 216-10-9260 29, 1908 Md. Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits i Hydiene. other than "natural", or flams 23s or 28s-1 show vent, the Medical Examiner must be notified at with the Maryla 1 ☐ Yes 2 No Director Baltimore Baltimore Md. 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 8830 Walther Blvd. Unit 317 21234 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black White, etc. hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 nent of Health and Menial Hygiene. ent: If Iham 27 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Mercantile Bank Corp. 12 Banker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Shaeffer Louise Edgar Taylor Annie Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mr. Robert K. Taylor, Sr./son 403 West Wind Ct. Street, Md. 21154 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If he any injury or off 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State 6/27/00 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service License 22, Name and Address of Fecility
Ruck Towson Funeral HOme, Inc. 1050 York Rd. Towson, Md. 21204 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) · Respiratory Failure 48 hours Examiner Due to (or as a consequenca of): Examiner 48 hours Bilateral Preumonio The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Box 68760. c. Lung cancer lyear by Physician/Medical Due to (or as a consequence of) USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease, Diabetes Mellitus Records, 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en eutopsy performed? Completed Parkinson's Disease, chronic atrial Fibrillation 1 Yes 2 NO 1 Yes 2 No cerebrovascular accident, Hypertension of Vital Physician: 25. Was case referred to medical axaminer? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Attending 1 Naturel 2 Accident spital or Attendin rours after death. neral Director: Aft filled in by the fur 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier vietelamos (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) June 10, 2000 MD 1753925 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 DR Sean BerenHoltz 9000 Franklin Square Drive Baltimore MD 21287 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State JUN 1 9 ZUUU ooks Registrar

DHMH 16 Ray 6/95

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth Month **Physician** Sara Catherine Tyrrell June 10,2000 4:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death B 21 136 7. Age (In yrs. last birthday) | Hunder 1 Year | If Under 24 Hrs. | 8. Date of 8 SOUTH OF FAWN GROUE HARFOUD 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) June 1, 1987 9. Birthplace (Stete or Foreign Country) District of Columbia **Funeral** Months Deys Hours Min 1 □ M 2 🛛 F 13 218-21-0484 Director Usuai Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Manyland Department of Health end Mental hygiene. Important: if Itam 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at 10e. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits rsi', or items 23s or 28s-f short Examiner must be notified at 1 Yes ZONo Director MD Harford White Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5133 Meadow Stream Garth 21161-9506 USA 12. Was Decedent Ever in U,S. 11. Marltei Status Wes Decedent of Hispanic Origin? (Specity Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American indien. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates: Bieck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student School 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Dennis Charles Tyrrell Margaret McGovern 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 1 6 1 5133 Meadow Stream Garth, White Hall, Md. Dennis C. Tyrrell 20a, Method of Disposition 20b. Place of Disposition (Name of 6/I5/00 Pylesville, MD oley, cremetary or other place) Mary's Catholic Cemetery 1 Buriai 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Spent) 21. Signature of Funeral Service 22. Name end Address of Facility J.J. Hartenstein Mortuary, Inc. riensiam S. Main St., Stewartstown, PA 17363 e, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, List only one cause on each line. 23a. Pert1. shock Enter the Approximate Interval Between Onset and Death Physician /Medical immediate Cause (Finel SNIDRIES MULTIPLE disease or condition resulting in deeth) TRAUMATIC Examiner Due to (or es e consequence of): MOTOR VEHICLE ACCIDENT attending physician end for use as the burief-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): ate hes been signed by the apage 2 should be deteched Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate hes 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica director Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ROther (Specify) P 1 No 2 No 27. Manner of Deeth 28d. Describe how injury occurred BELTED (ASSEN) Certification: 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28c. fnjury et Work? 5 ☐ Pending investigation 4.30P 1 Natural 1 Yes 2 No GER. CAR Lit whaten bo Pole UN 10, 2000 2 Accident filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 1 3 2 7 1 3 6 28e. Placa of injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide STREET 24 hours JUST JOUTH OFFAMH GROUD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and menner as stated To the Hosp within 24 ho To the Fune completely fi Medical (Check only one) 22 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred et the time, dete and placa, and due to the ceuse(s) end manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DME 20012 2000 OCME

30, Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

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BELAND

32. Registrer's Signeture

BELAIR MOZIO14

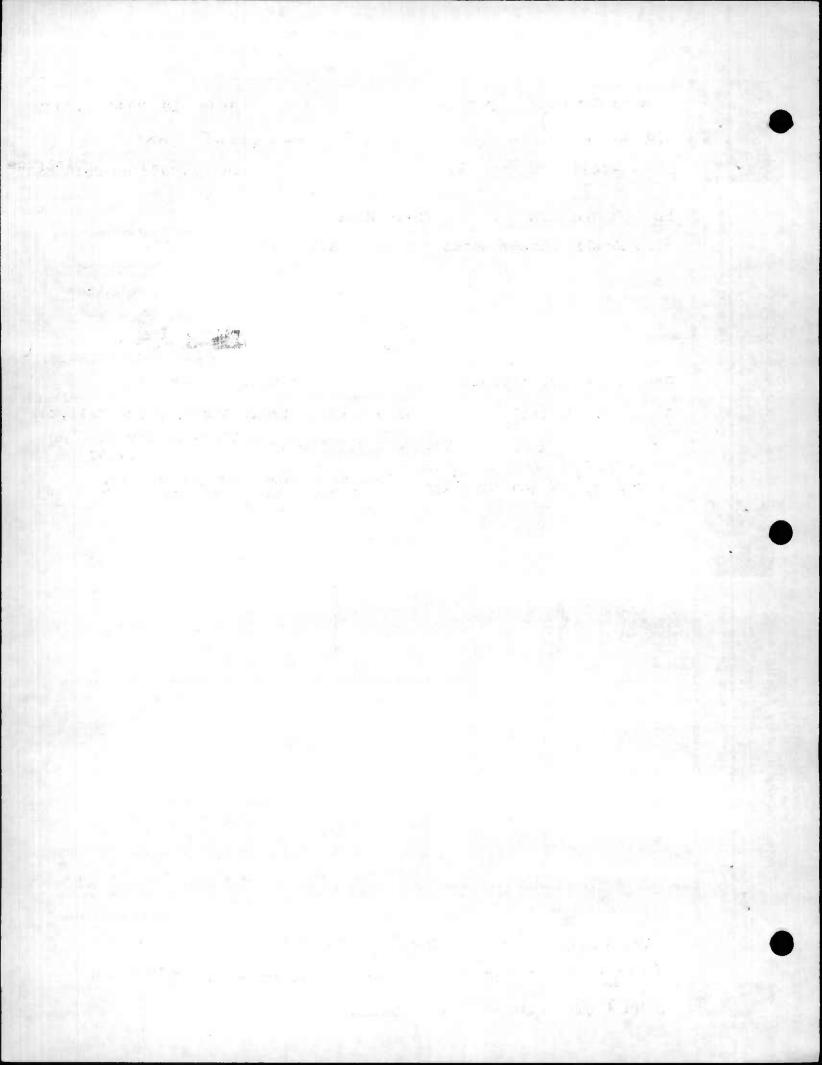
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JUN 1 9 2000

31. Date filed (Month, Dey, Year)

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 30 0 Reg. No. 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** 414 7:45 p.m. 10 2000 /Medical 4c. County of Death 4a Facility Nema (If not Institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 2434 Lauretta Avenue Baltimore N/A If Under 1 Year | If Under 24 Hrs. | Months Deys Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Months 86 Yrs. 219-10-4689 Md Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits or items 23s or 28s-f show 1 Ves 2 □ No Director Md N/A Baltimore 10e Street and Number 10f Zin Code 10g. Citizen of Whet Country? 2434 Lauretta Avenue 21223 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Race - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: if frem 27 is marked other than "natural", or he any lijury or other treumstic event, tre Medical Examina and 1 Naver Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementery/Secondery (0-12) 8th grade College (1-4or 5+) N/A Private Homes Domestic Worker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Dorsev Emma 19e. Informent's Neme/Ratationship (Type, Print) 19b. Mailing Addrass (Straat end Number or Rurel Route Number, City or Town, State, Zip Code) Carolyn Taylor - Daughter 3508 Fairview Avenue Baltimore, Md 21216 20b. Plece of Disposition (Neme of cemetary, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 D Buriat 2 ☐ Cremation 3 ☐ Removet from State 4 ☐ Donetion 5 ☐ Other (Specify) King Memorial Park 6/19/2000 Randallstown, Md 21. Signature of Furteral Service Licenses 22. Name end Address of Fecility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such es cardiec or respiretory arrest, shock, or hear feilure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth **Physician** ANCER Immediate Ceuse (Final diseese or condition resulting in daeth) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner attending physician and for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseesa or Injury that initiated events rasulting in death) Last Due to (or es a consequence of): Box 68760, Due to (or es a consequence of): signed by the a P.0. Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yss 2 No Records, ð 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 s has 280 No 1 Yes 1 ☐ Yes 2 1 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To this 28b. Time of 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Neturet 5 Pending Invastigation ours after death. wrai Director: Af filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide M hours Hospital 1 Certifying Physician: To the best of my knowledga, deeth occurred at the tima, date and place, end due to the ceuse(s) and mannar as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier To the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D'290 6:12:00

Registrar

State

31. Dete filed (Month

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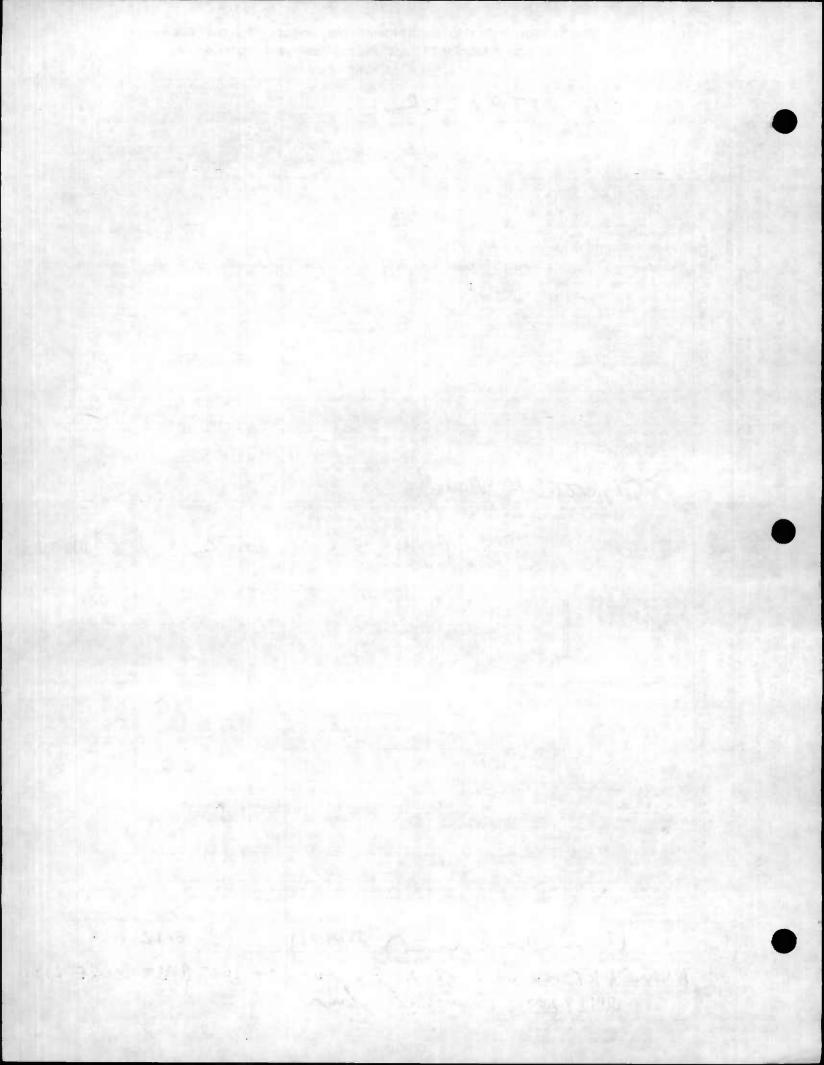
JUN 17

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

821 N.

32. Registrer's Signeture

EUTAW ST# 705 BALTIMORE 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death June 17, Edith **Volrath** 2000 6:15 PM M. 4e Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 1138 Armistead Street Glen Burnie Anne Arundel If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth Months Devs Hours Min. (Month, Dev, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Deys 1 M 2 XF 217-18-3578 March 29,1923 Maryland Usuel Residence of Decedent 10a Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1138 Armistead Street 21061 U.S.A. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. 1 Never Merried 2 Merried Yes 2 No 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates: Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Mary Viola Samue1 Howard Granger Stanley 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Andrea Volrath Daughter 1138 Armistead Street Glen Burnie, Maryland 21061 20b. Place of Disposition (Neme of cemetery, crematory or other plece) June 20 20e. Method of Disposition 20c. Location - City or Town, State 1X Buriel 2 Cremetion 3 Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Glen Burnie, Maryland Glen Haven Memorial Park 22. Name and Address of Facility Singleton Funeral Home, P.A. Signature of Funeral Service Licenses 1 Second Avenue, S.V 1M00264 Glen Burnie, Maryland 23a. Part 1. Enter the disease, on complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List pnly one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Pelvic Cancer Months Due to (or as a consequence of): Months

**Physician** Wedical **Examiner** 

**Physician** 

/Medical

Examiner

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Funeral

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**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Maryland 21215-0020

filed within 72 al Hygiene.

It. Pages 1 and 2 should be riment of Health and Mental riant: if Item 27 is marked o

Examine physician and the bunal-transit Physician/Medical 950 ed by the a signed by t à should ! Completed page 2 Be 10

P.O. Records, of Vital s after death.

I Director: After this code in by the funeral director. Division filled in by after after To the Hospital within 24 hours a To the Funeral I

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last

27. Menner of Deeth

1 Neturel

2 Accident

4 | Homicide

3 Suicide

29a. Certifier

Genitourinary Cancer Lung Mass

Due to (or es e consequence of)

Due to (or as a consequence of) G.I. Cancer

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medical 1 Yes 2 No

28a. Dete of Injury (Month, Day Year) 5 Pending investigation

6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Injury

28c. Injury et Work?

1 Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) and manner as steled.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) and menner steted.

24 No

24a. Wes an eutopsy

1 Yes

28d. Describe how Injury occurred

Other: 4 Nursing Home 5 M Residence 6 Other (Specify)

26. Place of Deeth (Check only one)

29b. Signature and title of certifier

29c. License number Duo 33 296 29d. Date signed (Month, Day, Year) June 19, 2000

Months

Months

24b. Were eutopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 1 Unknown

adjet 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil Padgett, M.D.

7711 Quarterfield Road Glen Burnie, Maryland 32. Registrar's Signature

oaks

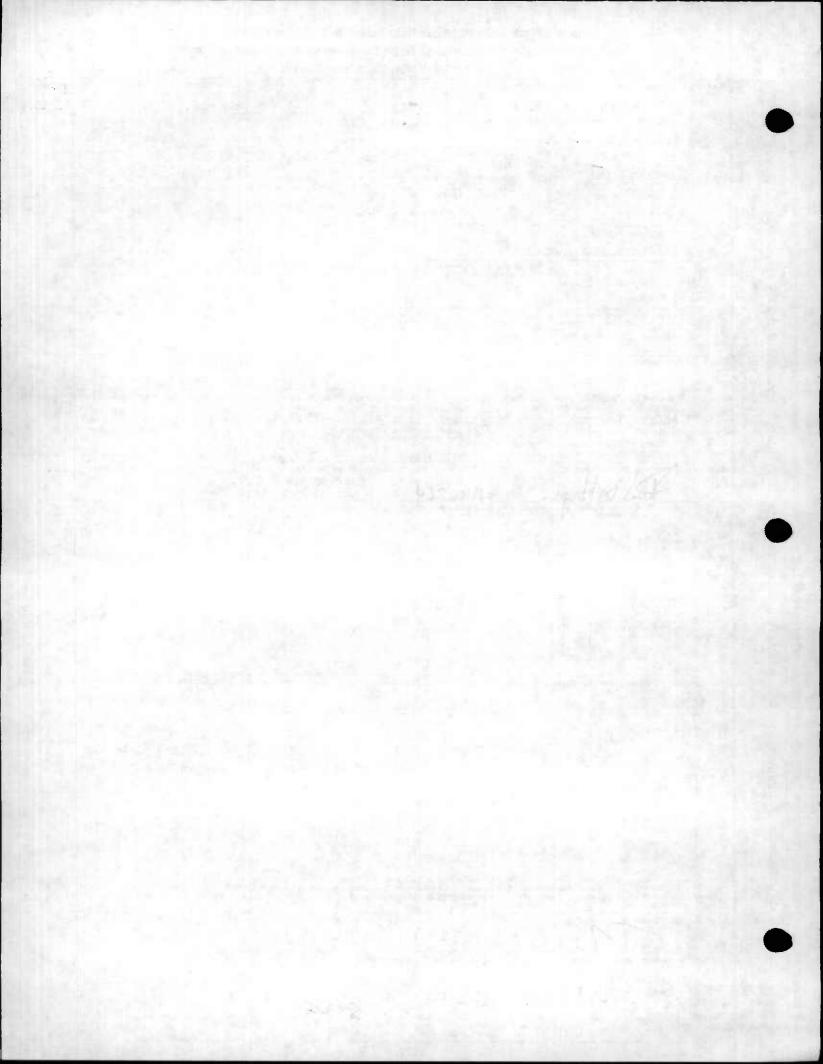
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Certification:

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DHMH 16 Rev 6/95

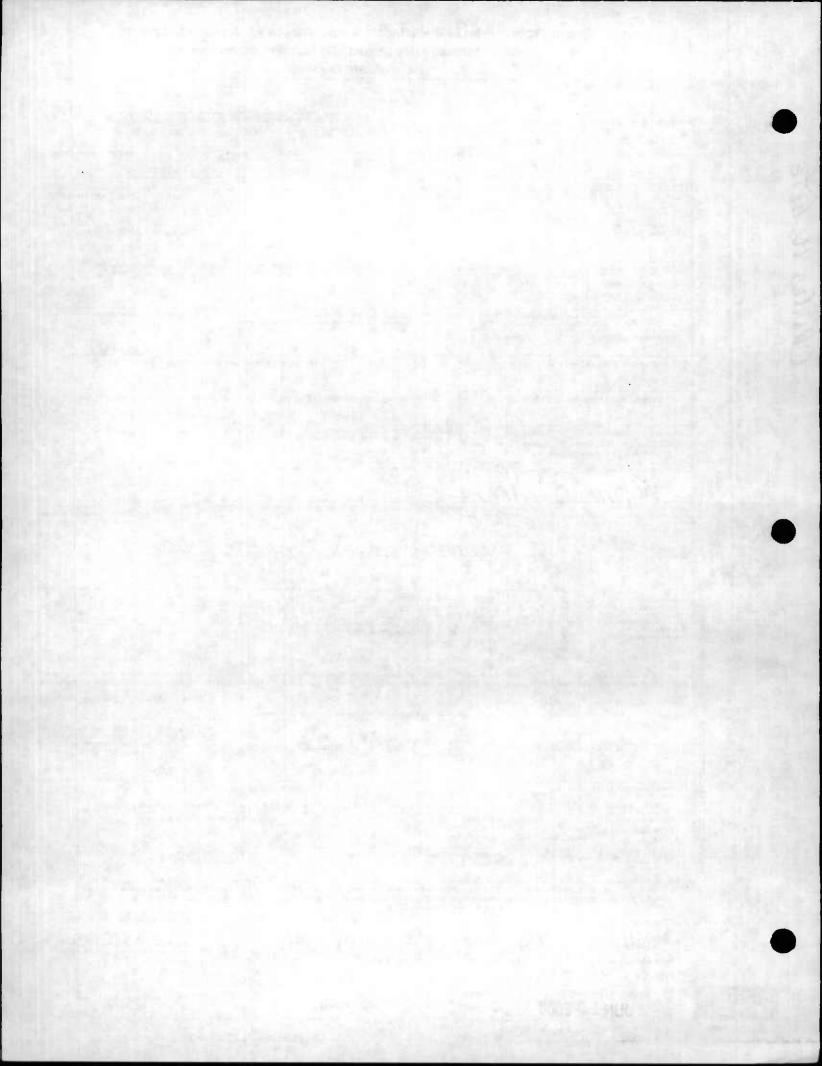


Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 2000 Charles E. White June 13, 12:00 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) Examiner 4427 Grandview Avenue Baltimore
| Hunder 24 Hrs. | 8. [
Hours | Min. | If Under 1 Year Months Days 5. Sociel Security Number 6. Sex 7. Age (In vrs. last birthdey) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 2 F Yrs. Director 220-20-2782 Aug. 3, 1927 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yas 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4427 Grandview Avenue 21211 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, While, etc. 1 Never Married 20 Married 1 ☐ Yes 2 No If Yes, Give 1 Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: White à 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Baltimore City Fire Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be III ment of Health and Mental H fant: If lisen 27 is marked off jury or other traumatic even Be Cleveland Howard White Sarah L. Bigham 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Helen White 4427 Grandview Avenue, Wife Baltimore, Maryland21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donglion 5 Other (Specify) Department of Important: If any injury or ance. Meadowridge Memorial 6/17/00 Dorsey, Maryland 22. Name and Address of Facility 21. Signatu Funeral Service License Burgee-Henss-Seitz Funeral Home, Inc. 23a Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respirelory arrest, meant failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Carcinoma Immediate Cause (Final disease or condition resulting in death) /Medical 8 mon Examiner Due to (or as a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medicai Due to (or es a consequence of): USB BS P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yea 2 ☐ No of Vital al or Attending Physician: T s after death. If Director: After this carificat ed in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) To. Other: 4 Nursing Home 5 AResidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 Ø No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certified June 13, 2000 the completed cause of death (Item 23a) (Type, Print) tadgett MD Charles 5601 Loch Raven Blud, Baltimore, NWD 21239 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State JUN 1 9 2000 Registrar DHMH 16 Rev 6/95 0 0 0004

**ORIGINAL** 

0 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** THETA BENNETT 18,2000 WALLACE 1;18 A.M. June /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Center Randallstown Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 4/22/13 9. Birthplace (State or Foreign Country) Rhode Island 7. Aga (In yrs. last birthday) **Funeral** Days Months 1 M 2 F 87 Director 039-14-7608 Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d, Inside City Limits or 28s-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Haaith and Mental Hygiene. Important: if itsm 27 is marked other than "natural", or farms 23a or 28s-f ahov any injury or other traumatic event, the Maritial Exampler main by notified at once. 1 ☐ Yas 2 ☑ No Director Md. Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4010 Buckingham Road 21207 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 Never Married 2 ☐ Married 1 Yas 2 No If Yas, Give Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Instructor Dance 12 Grade 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Benjamin Bennett Mary James 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Wallace (Son) 55 Bellchase Court Pikesville, Md. 21208 Earl 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 6/21/00 Spring Vale Cemetery East Providence R.I. 21. Signatura of Full 22. Nama and Addrass of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Md. 21136 aut, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. 23a. Part1. Enter the Approximata Interval Between Onset and Death **Physician** tmmediate Causa (Final disaasa or condition rasulting in death) /Medical nhurin Examiner Physician/Medical Examiner for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that Initiated events rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. Due to (or as a consequence of): ata has been signed by the page 2 should be detached Part it. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? tailer 1 Yea 2 No 3 Probably 4 diknown Division of Vital Records. þ Be Completed 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was casa ratarred to medical 26. Place of Death (Check only one) Other: 42 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA after death. Director: After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of tnjury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be detarmined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 4 Homicida 24 hours a Funeral D Medical 29a. Cartifiar 1 Certifying Phyaictan: To tha best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signatura and titla 29d. Data signed (Month, Day, Year) 29c. License number 6/19/0

DHMH 16 Ray 6/95

State

Registrar

30. Nama and address of person who

2000

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(er

838 Greene Tree Rd # 300

in (Item 23a) (Type, Print)

32. Registrar's Signatura

#### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9330 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Vest **Physician** 06 19; KOSCOE 2000 une WATSON /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street end number Examiner Kal The Johns **DOKINS** imore N/A 1 00 If Under 24 Hrs. Birthplace (State or Foraign Country)
 NC 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours Months 1 XM 2 F 63 Yrs. Dec 1936 Director 237-50-0566 Usuai Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. fnside City Limits "natural", or frems 23s or 28s-f show the Medical Exeminer must be notified at 1 Tayes 2 □ No Directo MD N.A Baltimore the 10g Citizen of What Country? 10a Street and Number 10f. Zip Code United States 21205 931 North Collington Avenue Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - Amarican Indien, Black, White, etc. filed within 72 hours after 1 Naver Merried 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0020 1 Yes 2 No à Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hospital Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) 12 Janitor other permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy, Important: If Nem 27 Is marked othe any Injury or other transfed othe 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Nama (First, Middla, Last) Be Bruce Wallace Beulah Wallace 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Routa Numbar, City or Town, Stete, Zip Code) 931 North Collington Avenue, Baltimore, MD 21205 Mrs. Ozelma Watson-Wife 20b. Pleca of Disposition (Neme of cematery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Suriel 2 Cremetion 3 Removal from State Jun 17 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Voshell Memorial Park 2000 21. Signature of Funeral Sarvice Licensee 22. Name end Address of Fecility Smith & Williams Funeral Home, P.A. alven Z. U 2818 East Baltimore Street Baltimore, MD Approximate tnterval Between Onset end Deeth 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final CARDIOMYOFATHY disease or condition resulting in death) ISCHEMIC 1 YEAR Examiner Due to (or as a consequanca of): Examiner YEARS ORONARY ARTERY DISEASE The law requires that the death certificate be executed attending physicien end for use as the burlal-transit Sequentially list conditions, if eny, leeding to immadiate causa. Enter Underlying Cause (Disease or trijury that initiated events rasulting in deeth) Last Due to (or as a consequence of) 10 Box 68760. YEARS HYPERTENSION Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Records, P.O. the Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. detached 1 Yes 2 No 3 Probably 4 Unknown been signed by ATRIAL FIBRILATION þ 2 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed CEREBRAL VASCULAR ACCIDENT completion of cause of death? has page 2 2 No certificate 1 Yes 1 ☐ Yes 2 No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) To Hospital: 1 km Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) s after deeth. of Director: After this could in by the funeral dire 1 Yes 2 No 28e. Date of tnjury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury 28c. fnjury et Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending Investigation 1 80 Naturai 1 Tes 2 No 2 Accident 6 Could not be 28t. Location (Street end Number or Rurel Route Number, City or Town, Stata) 3 ☐ Suicida 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only 29c. License number 29d. Data signed (Month, Dey, Year) 29b. Signatura and titla of certified , H.D

State Registrar

**DHMH 16 Rev 6/95** 

HOPKINS

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32. Registrer's Signeture

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

GRAF, M.O

2000

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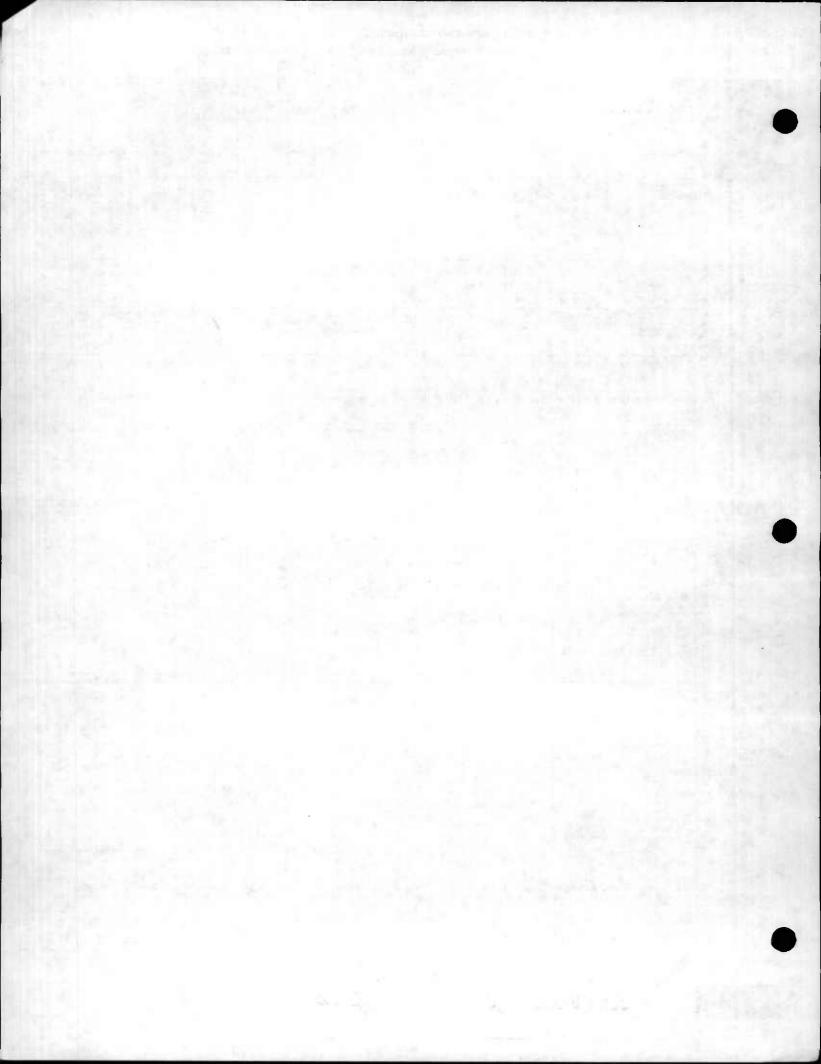
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31. Date tited (Month

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JUNE 14, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NORMAN SAMUEL YOUNG. 2000 TUNG /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number 4c. County of Death Examiner B/UE DOINT 5. Social Security Number BIUE Baltomore HIME JUrsing H Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)

DEC. 3, 19: If Under 1 Yeer 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days 18 M 2□ F Yrs. 2/3 58 4569 Usual Residence of Decedent Director maryLmo 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County POTES 2 No BALTIMARE Directo Haryl one 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ANONUE 21215 USB 5508 MINNOKA 12. Wes Decedent Ever in U.S.
Amed Forces?
1 Defes 2 No With Mark Give
17 Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marifel Status 1 Never Merried 2 Merried 8 1□ Yes 2DMo altimore, Maryland 21215-0020 specify: 8 lack Specify: þ 3 Widowed 4 Divorced nom Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Higiene. Mt. Waskington Elementary/Secondary (0-12) College (1-4or 5+) KEEDOR opts 12th grade Department of Health and Mental Hygis Important: If Item 27 is marked other: any injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental 2 loung Clova walker 10RMm 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5508 Minnoka AUG 10UNG BALFINOR, Mary/ono WIK 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Nethod of Disposition cemetery, cremetory or other pleca) Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility CAA framson forcet 4 □ Donation 5 □ Other (Specify) HALLIS FUNCIAL HUME 21. Signefure of Funeral Service Licensee 5240 REISTERSTUNN RIAN 23a. Part Enter the/disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirelory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Due to (or as e consequence of): Physician/Medical Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown rcephalopathi Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No of Vital Be 25. Was case referred to med examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 Medical Certification: To To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 BNaturai 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, sfreef, fectory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and fitte of cartifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suit 300 Pirerville, MD 21208 all of It 838 State 32. Registrar's Signature Registrar

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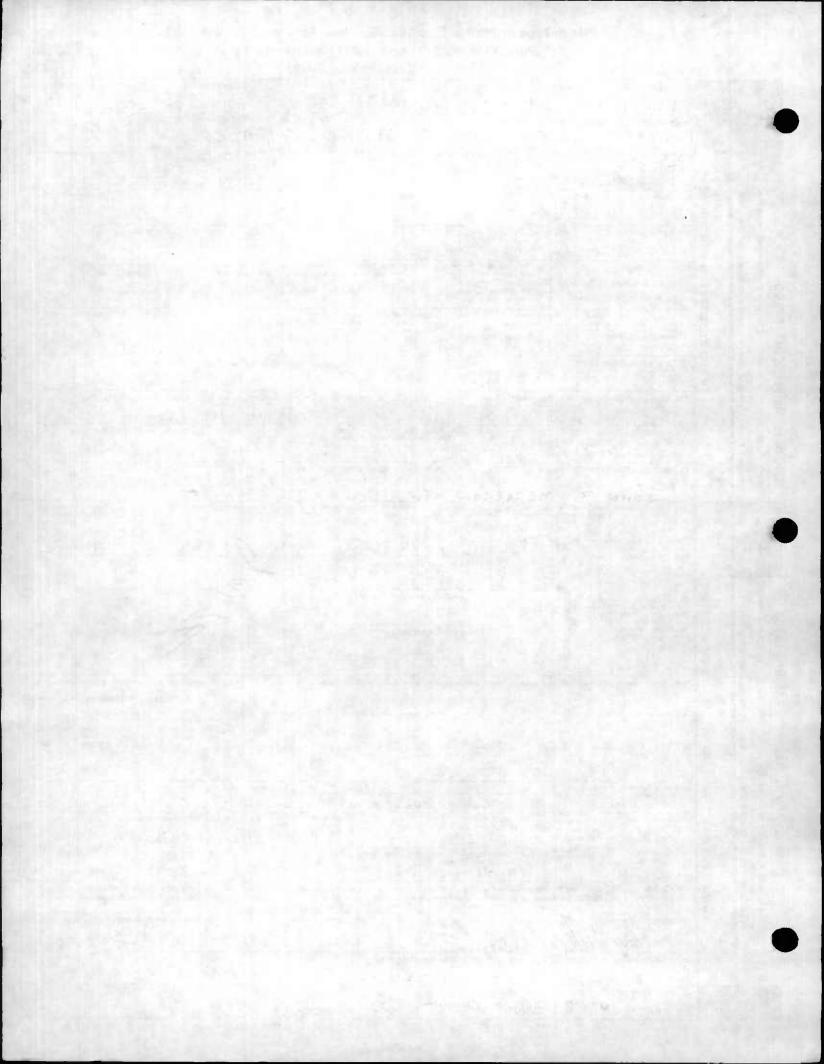
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213-14	Baltimore, semit. Pages 1 ar appartment of Hea montant: if Nem? my injury or other mos.		20a. Method of Dis 1 ☑ Burial 2 4 ☐ Donetion		Hemover from State			ce of Disposition (Name of netery, crematory or other place) mico Memorial Park						cation - City or Town, State lisbury, MD			
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	3270	Cer	4 Homicide building, etc. (Specify)  29e. Certifier  City or Town, Stete)  29e. Certifier  Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.														
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dical	VIKG	INIA	SOPHIA	BRAK	SANL		# 65 T	MAY	- 0	2000	1 15 /		
1161			e street end number) MARY U	main an	MICA		4b. City, Town, or	TIMO RE	Polt #1	imore	City		
	UNIVERS			e (In yrs. last bin		nder 1 Year				O Dieb-	lace (State or Foreign		
	337-03-2 Usual Residence	. (Month, De	n, Dey, Year) Country) 14,1913 Illinois										
- }-	10e. State	10b. County				1	0d. Inside City Limits						
	WI	Waushara		Spri	ngwate	r			1 □ Yes				
t	10e. Street and N	umber	17/71 611.6	10f. Zip Code						What Cour	itry?		
	W5633 Ar	cher Lane			U.S.A.								
		nied 2 Merried 4 Divorced	Armed Forces?	1 ☐ Yes 2 ☑ No ff Yes, Give			dispanto Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	No- 14. Rece - American Indian, Black, White, etc.  Specify: White				
		15. Decedent's Ed	ducetion	16a.	Decedent's l	Jsuel Occup	pation		16b. Kind of B	usiness/înc	dustry		
ŀ	(Specification)	ecify only highest gra	de completed) College (1-4or 5	e completed)			during most of wo	orking					
	12	Soridary (0-12)	College (1-40)	Homema	ker			Own	n Home	2			
		(First, Middle, Last)			ame (First, Middle, Meiden Surneme)								
-	August	Patzer					Catherin	ne Ewald					
	19a. Informant's I	Name/Relationship (	Type, Print)	19b.	Meiling Add	ress (Street	end Number or R	ural Route Numb	er, City or Town	, Stete, Zip	Code)		
	Robert	Braband /	Son	19	W18th	Stree	et Lomba	rd. T11i	nois 601	148			
-	20a. Method of Di			20b Place of	Disposition	Neme of		Date	20c. Location	- City or To	wn, State		
		2 ☐ Cremation 3 ☐ 5 ☐ Other (Specification 2)		Saxev	ille U	nion (	Cemetery	6-1-00 Town of Sax			ville. WI		
	21. Signeture of Funeret Service Licensee  22. Name end Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A.  23. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, onset and Death  Approximate Interval Between Onset and Death												
	Immediate Cause (Finel disease or condition esulting in death)  a. PELVIC FRACTURE  Due to (or as a consequence of):  Bequentielly list conditions, fany, leeding to immediate cause. Enter Underlying										WEEKS		
	Sequentially list of any, leading to cause. Enter Und	conditions, immediate deriving	b	Due lo (or es e o	consequence	of):		i					
	Ceuse (Disease or Injury c. thet initiated events Due to (or as e consequence of):								#				
	resulting in death	Casi						1	1				
			d				STAN STAN	-					
1	Part II. Other sign	ificant conditions of	ontributing to death be	ut not resulting Ir	the underlyi	ng cause gi	ven in Pert f.	23b. Dfd	tobacco uee co	ontributa to	the cause of death?		
				1	1 Yes 2 No 3 Probably 4 Unknow								
	L.,	4							s an autopsy ormed?	av	ere eutopsy findings ailable prior to mpletion of ceuse death?		
								10	Yes 2000	10	Yes 22 No		
	25. Wes case refe	erred to medical					26. Plece of De	ath (Check only	one)	-1			
	axaminer?	□No	Hospital:	nt 2 ER/Ou	tpatient 3	DOA OU	ner: 4 Nursing I	Home 5□Res	idence 6 DOt	ner (Specif	y)		
	27. Manner of Dec		28a. Date of Inju (Month, De		Time of njury	28c. Inju Wo	y at	28d. Describe	28d. Describe how injury occurred				
	1 Natural 2 Accident	5 Pending investigation	0.0		IO AM		Yes 2 No	Fell	in chu				
	3 ☐ Suicide 4 ☐ Homlcide	6 ☐ Could not be determined		ury - At home, fa	rm, sireet, fa	281. Location (Street end Number or Rural Route Numb City or Town, Stete) 19 34 HARBOR DRINE CHESTER							
	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	yalcian: To the best of niner: On the basis of and manner sta	examination en	, death occur d/or investiga	red et the ti tion, in my d	me, dete end plec opinion, deeth occ	e, end due to the urred at the time	cause(s) and m , dete end plece,	enner es s and due to	tated. the cause(s)		
											signed (Month, Dey, Year)		
	> 74	yd lllu	Welly	4		124	24	MAY 28 2000					
1	RAA I	De La Company	completed cause of d	eeth (Item 23a) (	Type, Print)	- ST	REET, E	BOITIAN	DF M	0			
	31. Dete filed (Mo	onth Day Years	32 Paginter	ags Signeture	REET	2 01	rue , p	11-1111	11-1				
	oote med (MC	RANV 9 1		herewar	4	1							



#### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 26, 2000 William Babb 7:40 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 218 Oueen Anne Club Drive Queen Anne's Stevensville If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Yaer) 5. Social Security Number 9. Birthptace (State or Foreign Country) 8 New York 7. Aga (In yrs. last birthday) 167M 2□F Min. (Month, Day, Yaer) September 14, 009-03-9091 Yrs. 81 1918 Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Oueen Anne's Stevensville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 218 Queen Anne Club Drive 21666 TISA 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American indian, Black, Whita, atc. 1 Never Married 20XMarried Doves 2 No if Yes, Give Year or Dates: 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Eiamentary/Secondary (0-12) College (1-4or 5+) Food Broker Food Service 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) Haven Chester Babb Ida Sutherland 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Nancy Babb / Wife 218 Queen Anne Club Dr. Stevensville, MD 21666 ace of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cemetary, crematory or other piece) 20a. Method of Disposition Date 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation May 27, 2000 Stevensville, MD 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home s that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast. 23a. Part1. Exter the disease, or complication shock, or heart failure. List only one call. Approximata Intervat Batween Onset and Death immediate Cause (Final disease or condition resulting in death) upected myocardial intarctron Due to (or as a consequence of): Coronary artry direare Sequentially iist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury Due to (or as a consequenca of): that initiated avants resulting in death) Last Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to Chronic dementia 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

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Completed

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**Funeral** 

Director

show

7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed with Coppartment of Health and Mentel Hygien importants: if fam 27 is marked other that any injury or other traumatic event, that once.

the Marylend

filed within 72 hours effer

Baltimore, Maryland 21215-0020

the buriel-transit he ettending physician as 950 Por 2 certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifical completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

certificate be

Physician/Medical Examiner þ Completed Be 2

State Registrar

Normal pressure 25. Was case referred to medical examiner? Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Daath Medical Certification: 5 Panding investigation 1 Naturai 2 Accident 3 Sulcide 6 Could not be detarmined 28e. Placa of injury - At home, farm, street, factory, office building, atc. (Spacify) 4 Homicida 1 Certifying Physician: To tha best of my knowladga, daath occurred at the time, date and placa, and due to tha cause(s) and manner as stated.
2 Medical Examíner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) 29a. Certifian (Check only one) 29b. Signature and title of certifie

Data of injury (Month, Day Year)

NIA

28b. Tima of

29d. Date signed (Month, Dey, Year) 29c. License number

Other: 4□ Nursing Homa 5 Presidence 6 □Other (Specify)

28d. Dascribe how injury occurred

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

2000

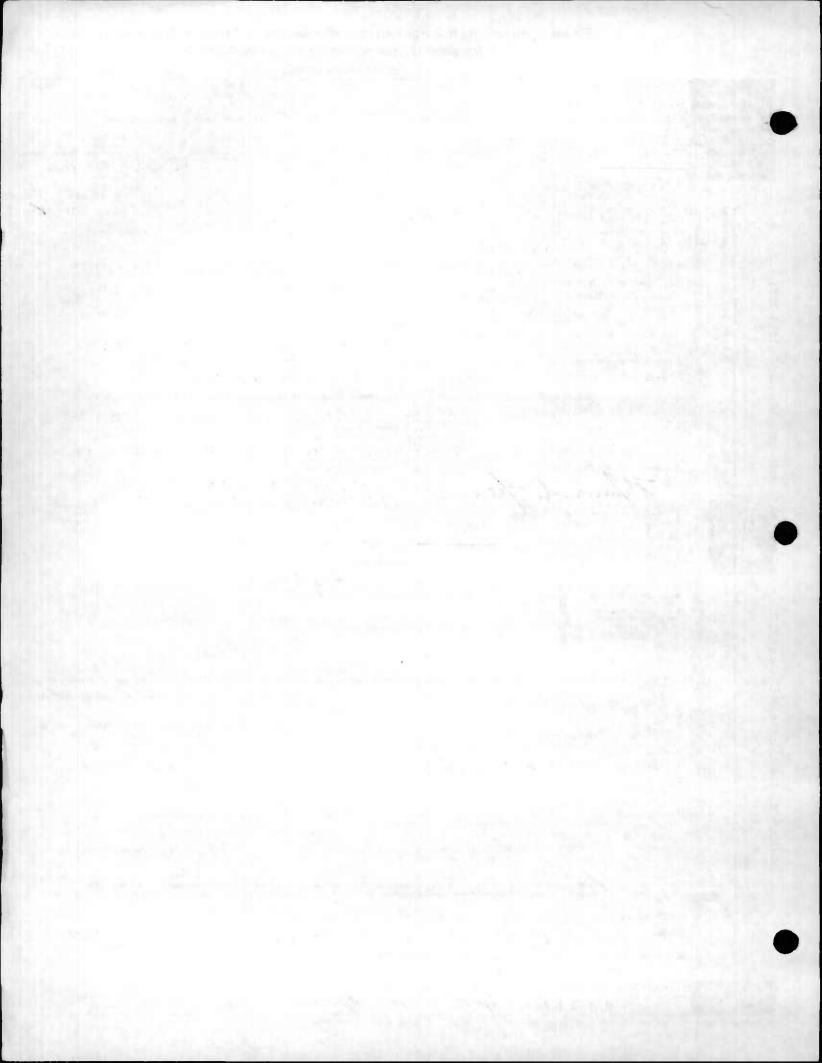
26. Place of Death (Check only one)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Konick

31. Data filed (Month, Day, Year) 32. Registrar's Signatura MAY 3 1 2000

28c. injury at Work?

1 ☐ Yes 2 ☐ No



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Veal **Physician** BAldIGOWSKI 1008 24 2000 ANCIS /Medical 4e Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Burnie Glen CYAIN Highway North If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Deys | Hours | Min. | North, Pay. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Sociel Security Number **Funeral** . 1927 Pennsylvania 18 M 2□F Director 188-20-2167 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Menyland Department of Health end Mental Hygiene.
Important if them 37 is marked other than "natural", or items 23e or 28e-f show any injury or other transfer ovent, the Medical Exercise must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 TYes 2 No Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 102 Crain Highway North TISA 21061 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian 11. Meritel Stetus Bleck, White, etc. 1 □ Never Married 2 □ Merried 1 Yes 2 No Specify: White Baltimore, Maryland 21215-0020 P 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Grocery Store 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be John Baldigowski Rose Krechiek 0 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Poznak, sister 478 Fannie Street, McDonald, PA 15057 Dete 30 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete May 3 2000 1 & Burial 2 Cremation 3 Removal from State Glen Burnie, MD Glen Haven Cemetery 4 ☐ Donatign - 5 ☐ Other (Specify) Parranco & Sons, P.A. Severna Park Funeral Home 21 Signature of Funeral Service Liopis 495 Gov. Ritchie Hwy., Severna Park, MD 21146 AS IPAI caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, use on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Final disease or candition resulting in death) /Medical Heart Disease erioselerotic Examiner Due to (or es a consequenca of): physician and a the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. The lew requires that the death certificate be executed Due to (or es e consequence of): Exa Division of Vital Records, P.O. Box 68760, Physician/Medical at initiated events sulting in death) Last Due to (or es e consequença of) 8 gribneria 887 23b. Did tobacco use contribute to the cause of death? been signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings aveileble prior to completion of cause ot deeth? Completed 24e. Was en eutopsy ils certificate hes t director, page 2 s 1 ☐ Yes 2 5 No 1 □Yes 2 □ No i Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certifica etely filled in by the funeral director, p Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of Certification: 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide Att. In 24 hours. The Funeral Direction 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner steted. To the Hospi within 24 hou To the Funer completely fil 29e. Certifier Medical 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number Deputy

tmerica

nd eddress of person who completed cause of deeth (item 23a) (Type, Print)

Day, Year)

ONCS M 32. Registrer's Signeture

State Registrar

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The Control of the Co

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed

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**Funeral** 

Director

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filed within 72 hours after

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Health a

Pages 1 of nant of He

Department of Health a Important: If Item 27 is any injury or other tra

Baltimore, Maryland 21215-0020

Physician/Medical Examiner þ Be Completed

2 Accident

3 Sulcide

29a, Certifier (Check only one)

4 Homicide

attending physician and for use as the burial-transit P.O. Box 68760. The lew requires that the death certificate be signed by the al Records, director, page 2 should certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifications. Medicai Certification: To filled in by

Division of Vital within 2 To the To the

H+18-24-618

DAVID BOZMAN

State Registrar

29b. Signeture end title of cartifier

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

JALI

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

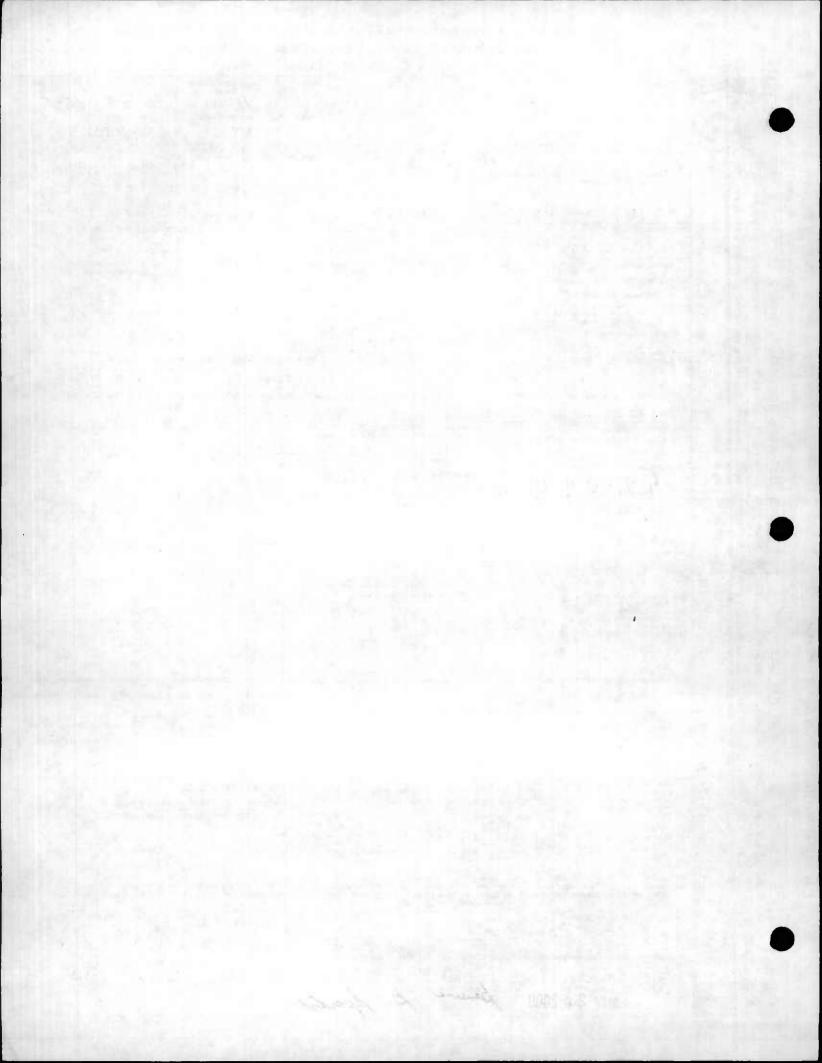
30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print)

Robins WILLAM 1104

31. Date filed (Month, Dey, Year)

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #1 HCHD 6/2/00 SR Certificate of Death 1. Decedent's Name (First, Middle, Last) Edmund George Cummings 3. Time of Death 2. Date of Death Day Month Year Physician रस्य साम्राज्य स्टेन्स्ट्रेन्स्ट्रिन्स MM 30 2000 0645 /Medical 4b. City, Town, or Location of Death 4a Facitity Name (If not Institution, give street and number) 4c. County of Death Examiner 7. Age (In yrs. lest birthday) If Under 1 Year BACTIMORE UNIVERSITY OF MARYLAND If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1₽M 2□ F Director New York 094-20-4289 with the Meryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2√ No Directo Maryland Harford Bel Air 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? items 23s or 205 East Heather Road Funeral 21014 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours effernent of Heelth and Mentel Hygiene.
Int: If ifem 27 is marked other than "natural", or its 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: þ Specify: XXWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Research Physiologist U.S. Government Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Edmund Henry Cummings Elizabeth (u/k) Wrench 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, Informant's Neme/Relationship (Type, Print) permit. Peges 1 and 2.
Department of Heelth 1.
Important: If item 27 is any injury or other 1. Lauren Cummings/Daughter 288 Norris Road, Airville, PA 17302 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burlai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 6-2-00 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate triterval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical LEUKO STASIS EKHT HOURS Examiner Due to (or as a consequence of): Physician/Medical Examine TWIFE MY GROGEHOUS LEVILEMIA The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieled events resulting in death) Last burial-tran and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Due to (or as a consequence of): the P.O. Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown yd bengis Records, þ 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed **pege 2** certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital director. Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No Director: After this d in by the funeral di 28b. Time of 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P 1 Netural 2 Accident Division 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 624 hours a To the Hospital
within 24 hours a
To the Funeral C
completely filled 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number MF Kuberterd MD P10277 MAN 30, 2000 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JESSUP, MARYUMD 20794 JOHNA M.F. RUBENFOLD

State

31. Date filed (Month, Dey, Year)

JUN 0 2 2000

Registrar **DHMH 16 Rev 6/95** 

32. Registrar's Signature

8187 ASPON WOOD WAY

that we will not be some winter to the 

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Rafael Angel Cintron May 29, 2000 5:45 PM /Medical 4e. Fecility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 11039 Bowerman Road Baltimore Baltimore Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthpiece (Stefe or Foreign Country) Months MM 20 F 145-34-0861 Director 56 Sept. 23, 1943 Puerto Rico Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show with injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 11039 Bowerman Road 21162 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. Bleck, White, etc. 1 Ryes 2 No If Yes, Give Yeer or Detes: 1962-66 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 Divorced Puerto Rican Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Electrician Coffee Manufacturer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Cintron Cadiz Jose (u/k) Bertha (u/k)19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 77 W. 7th Street, Bayonne, NJ 07002 Coria Cintron/ Daughter 20b. Plece of Disposition (Name of cemetery, cremetery or other plece)
New Jersey Veterans 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ₺ Burial 2 ☐ Cremetion 3 ₺ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 6-5-00 Arneytown, New Jersey Memorial Cemetery ature of Funeral Service Licensee 22. Neme end Address of Fecility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23e. Peri Ent in disease, or complications that caused the district Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the district Control fellure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) **Examiner** Examiner End stage liver physician and s the burial-transit certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of): resulting in deeth) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. Records, P.O. 23b. Did tobacco use contributa to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Esophageal Varices 24b. Were autopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA this filled in by the funeral 27. Menner of Deeth 28e. Dete of injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Affer 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fune. 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pieca, and due to the cause(s) end menner steted. edical 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 048215 5/30/00 mark D. Henser, mD 30. Neme and eddress of person who completed cause of deeth (item 23e) (Type, Print) Perry Point VA Medical Center 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JUN 0 2 2000 Registrar

DHMH 16 Rav 6/95

Melina Premater and Malle

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificate	e or i	Death			Reg. No.		12002		
	1. Decedent's Name (First, Mide	dle, Last)	4						2. Date of De		Year	3. Time of Death		
sician edical	VIRGIL GEOR						May	20	2000	06:26 A.M.				
miner	4a Facility Name (If not instituti	on, give street and nu	umber)			4	4b. City, To	wn, or Lo	ocation of Death	4c. Co	ounty of Death			
	Route	305 & Car							ville	Qı	ieen Ar	ne's		
	5. Social Security Number 004-16-9474	6. Sax 1∭ M 2□ F	7. Aga (In yrs. 82	last birthday) Yrs.	If Under Months	1 Year Days	If Undar Hours	24 Hrs. Min.	8. Date of Bird (Month, Da SEPT 2,	1917	9. Birth Cou MA	nplace (State or Foreign INE		
	Usual Residence of Decedent  10a. State 10b. Count	v	10c Ci	ly Town or Lo	ocation	-						10d. Inside City Limits		
ctor										1 Yes 2 No				
al Directo										10g. Citizan of What Country? USA				
by Funeral	11. Marital Status  1 Never Married 2 Marital 3 Widowed 4 Divorce	12. Was Dec Armed F rried 1 ☐ Yes If Yes, G	Armed Forces?			Was Decedent of Hispanic Origin? (Specify Yas of Yes, specify Cuban, Maxican, Puerto Rican, etc.  1 ☐ Yes 2X No Specify:					or No- 14. Race - Amarican Indian,			
	15. Decede (Specify only high	16a. Dece	6a. Decedent's Usual Occupation (Give kind of work done during most of working						16b. Kind of Business/Industry					
Completed	Elementary/Secondary (0-12)	1	College (1-4or 5+)			se retired	d)	I OF WORK	ing .					
3	17. Father's Name (First, Middle	, Last)	2   INN KEE				18. Mothe	r's Name	e (First, Middle,	HOTEL  lle, Maiden Sumame)				
o Be	GEORGE FRED				SARA									
	19a. Informant's Name/Ralation	19b. Malli	. Malling Addrass (Street and Number or Rural Route Number,						; City or Town, State, Zip Code)					
	KATHRYN CROCK	ETT / WIFE						LANE	7					
	20a. Method of Disposition  1 Burial 2 Acremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  CHESAPEAKE CREMATION CTR. 5-23-00  STEVENSVILLE, MD													
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617													
	23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dyling, such as cardiac or respiratory arrest, shock, or heart taiture. List only one cause on each line.  Approximate Interval Between													
n al	Onset and Death													
	disease or condition resulting in death)  MULTIPLE INJURIES  Due to (or as a consequence of):													
iner	Due to (o) as a consequence on).													
i Examiner	Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause, (Disease or Injury C.													
Medical	that initiated events  Due to (or as a consequence of):  presulting in death) Last													
cian			22h Did tohance was southful to the same of the											
Physician	Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death  1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknow				
Completed by										an autopsy	Wara autopsy findings available prior to complation of causa of death?			
mo									17(2)	Yes 201	No x	Yas 2 No		
Be	25. Was case raterrad to medic examiner?							of Deat	h (Check only o	ona)				
2	XIX Yes 2□ No			ER/Outpatie			4 LINU	ursing Ho	me 5 Rasi	- 41	Other (Spec	%Scene		
Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work?  Natural 5 Pending (Month, Day Year) Injury Work?  1 Yas XXNo									28d. Dascribe how injury occurred Driver of motor vehicle Collides with amother vehicles. Under which are the color of the				
Medical Certification:		ing Physician: To the I Examiner: On the b	a best of my kno									stated.		
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	29b. Signatura and titla	ar	Λ.	11	290	29c. Licansa number 29c. C.M.E.					29d. Date signed (Month, Day, Year)  May 21, 2000			
Me	1 He	Mune	- , 1	1-17		0	.C.M.	Ε.		Ma	y 21,	2000		
Mec	30. Name and address of perso	n who completed cau	1 (4)			-44	19%		timore,					

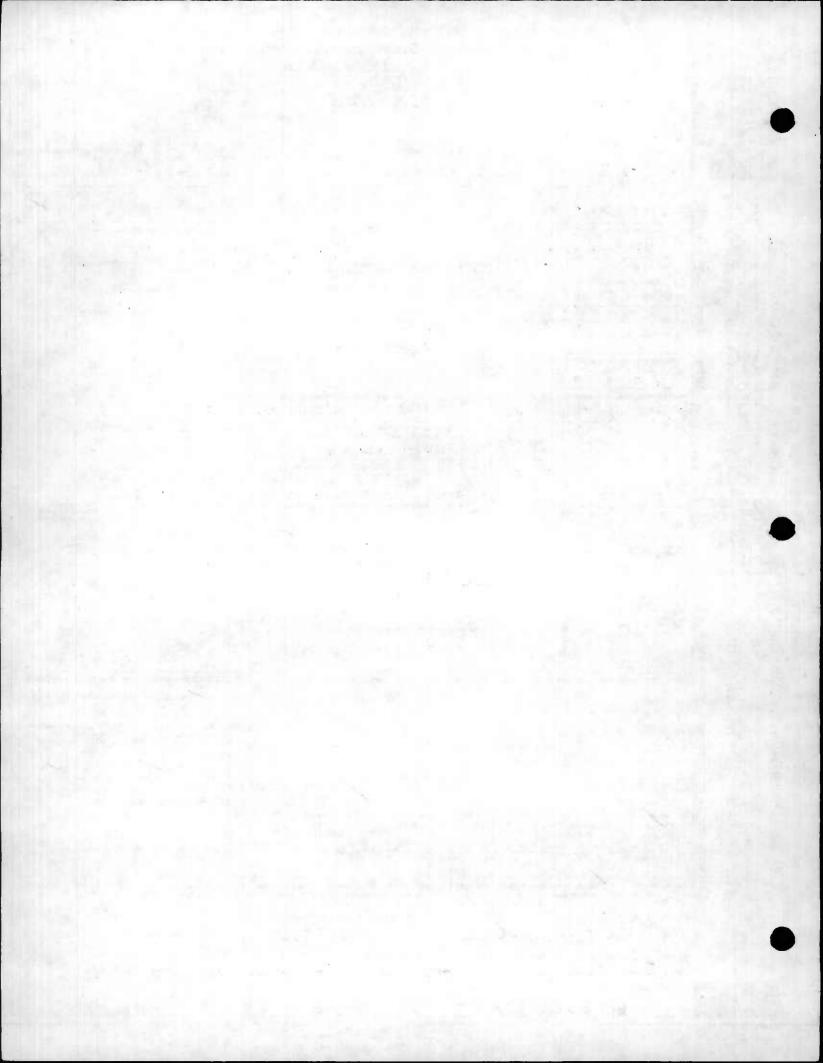
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla Last) CHANCE **Physician** ROSEMARY 7:08 AM May 23, 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel # Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | January 29, 1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 20 F Yrs. 72 Director 215-24-5203 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Queen Anne's 28a-f Directo Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 112 Dundee Avenue 21619 IISA Funeral 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yas 2 Ø No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Nevar Married 2 Married b Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) filed within Mailing Elemantary/Secondary (0-12) College (1-4or 5+) 8 Assembly Worker Production 18. Mother's Nama (First, Middle, Maiden Surname) 17. Falhar's Nama (First, Middla, Last) permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic ave Bessie Anna McCoy William Andrew Cosden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) 1744 Hope Rd Centreville, MD 21617 Wallace L. Chance, Jr. 20b. Place of Disposition (Name of cematary, cremetory or other place, 20a, Mathod of Disposition 20c. Location - City or Town, Stata Burlal 2 Cramation 3 Ramoval from Stala 4 Donation 5 Other (Specify) May 26, 2000 Crumpton, MD Crumpton Cemetery 22 Nama and Address of Facility 21. Signatura of Funaral Sarvice Licenses Fellows, Helfenbein & Newnam Funeral Home 23a. Part. Entar the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert tellure. List only one cause on each line. 106 Shamrock Rd. Chester, MD 21619 Approximata Intervel Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting In deeth) /Medical Examiner Examiner Sequentially list conditions, if any, laeding to immadiata causa. Entar Undarlying Causa (Diseesa or injury that initiated evants rasulting in death) Last physician and s the burial-trans Dua to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of) signed by the a P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed by Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy i certificate has t 1 Yes 2 THO 2010 1 Yes Division of Vital or Attending Physician: director, 8 25. Was casa rafarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28a. Dele of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Panding To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No Investigation 2 Accidant 6 Could not be datermined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Cartifiar Medical (Check only one) 29c. License number 29d. Dala signed (Month, Day, Year) D37064 ddress of person who completed cause of death (Item 23a) (Type, Print) es Chambales Stevensville Mi 130 Love Pt 31. Data filed (Month, Dey, Year) 32. Registrar's Signature State

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Registrar

2 5 2000



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day **Physician** 2000 RUSSELL J. CORNISH SR. JUNE 3 5:15 am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTER If Undar 24 Hrs. QUEEN ANNE 105 PRICE ROAD 5. Social Security Number If Under 1 Year 8. Dete of Birth Month, Day, Year) JUNE 4 1912 8. Sex 7. Aga (fn yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Hours Months Days 170 M 20 F MARYLAND Yrs. 87 Director 217-10-8590 Usuei Rasidence of Decedani death with the Meryland 10d. Inside City Limits 10a Slata 10c. City, Town or Location 10b. County worle flem 27 is marked other than "natural", or flems 23s or 28s-f shot other traumatic event, the Medical Examinar must be notified at 1 Yas 2 □ No Director MARYLAND QUEEN ANNE CHESTER 10e Street and Number 10g. Citizan of What Country? 10f. Zip Code 21619 105 PRICE ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? XOXVes 2 □ No If Yes, Give Year or Dates: W . W . II 13. Was Decedant of Hispanic Origin? (Specify Yas or No-# Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Merital Status Black, Whita, atc. filed within 72 hours after 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: BLACK Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Businass/Industry end Mentel Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) MEARS POINT 4th 0 GROUNDS KEEPER MARINER permit. Peges 1 and 2 should be filk Department of Health and Mentel Hy Important: If Nem 27 is marked other any injury or other trauments event 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Be 2 ENOCH CORNISH MARY CREIGHTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) LEOLA CORNISH (DAUGHTER) 105 PRICE RD. CHESTER, MARYLAND 21619 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Data \*\*Burial 2 Cremetion 3 Ramoval Irom Stata 4 ☐ Donation 5 ☐ Othar (Specify) 6/7/00 CHESTER, MARYLAND UNION WESLEY CEME. 21. Signeture of Funarei Sarvice Licensas WM. REESE & SONS MORTUARY, P.A. M00482 821 else WEST ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onsat and Death **Physician** /Medical Immediata Causa (Final new disaasa or condition rasulting in death) Examiner Due to (or as a consequence oi): Examiner be axecuted physician and s the burial-trans Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as e consequence of) 9SU Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ Records. 24b. Ware autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 certificata has 21 No 1 Yas 1 Yas 2 No of Vital 25. Was casa ralarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Aasidance 6 Other (Specify) 1 Yas 2 No 2 this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Tima ol Injury 28c. Injury at Work? 28d. Dascribe how injury occurred After Division ars effer death. 1 Natural
2 Accidant 5 Pending invastigation 1 Yas 2 No 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - Al homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicide To the Hospital
within 24 hours e
To the Funeral C
completely filled i 24 hours e Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Cartifiar (Check one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and fitte of certifier 30. Nems and addrass of person who completed cause of death (Item 23a) (Type, Print) 204 Medica ibby KAIPH E.

DHMH 16 Rev 6/95

State Registrar Year)

32 Registrar's Signatura

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Year NORMAN JOSEPH COOPER MAY 29 2000 9:00 AM 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 36384 POPLAR NECK ROAD WILLARDS If Under 24 Hrs. WICOMICO If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Min. 1X M 2□ F Months Days Hours Yrs. 218-16-9958 80 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits 1X Yes 2 No WICOMICO WILLARDS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36384 POPLAR NECK ROAD 21874 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 N Merried If Yes, Give Yeer or Detes: 1942/45 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) FOREMAN STATE GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) CLARENCE STELLA BRATTEN 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUISE V. COOPER/WIFE 36384 POPLAR NECK ROAD, WILLARDS, MARYLAND 21874 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) NEW HOPE CEMETERY 6/1/00 WILLARDS, MARYLAND 21. Signature of Foherei Service Licer 22. Name and Address of Fecility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 41 23a. Perf. Enter the disease, or complications that or used the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause or much line. Approximete Interval Between Onset and Death Immediete Ceuse (Finei diseese or condition resulting in deeth)

**Physician** /Medical **Examiner** 

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Examiner

Physician/Medical

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Medical Certification:

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumatic event price.

**Physician** 

/Medical

Examiner

10a. State

MARYLAND

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**Funeral** 

Director

'natural', or liams 23s or the Medical Examiner must be

filed within 72 hours after

Saltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest

Due to (or as a co ormi Due to (or s a consequence of Due to (or es a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Netural 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

29e. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier

29d. Dete signed (Month, Day, Year) 30 0

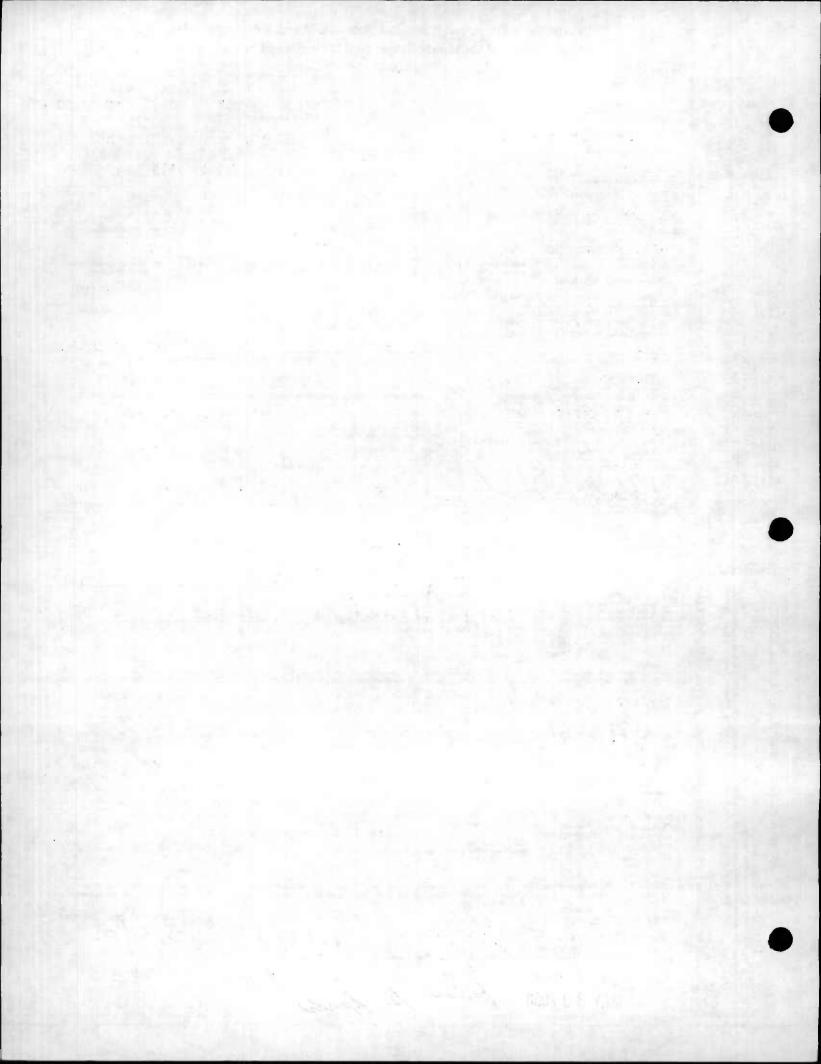
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

2

8138 padros . Soulisbury MO boso h 31. Dete filed (Mon 32. Registrar's Signeture 0 2000

State Registrar

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3 Time of Death **Physician** Month James A. Collins 19 2000 May 6:10 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4671 Timmons Rd. Powellville Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 9, 1938 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2□ F 62 Yrs 217-36-2017 MD Usual Rasidenca of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Nas 2 No Director MD Wicomico Powellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4671 Timmons Rd. 21852 U.S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marifal Status Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 farm laborer farming 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dallas Johnson Grace Collins 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Collins/wife 4671 Timmons Rd, Powellville, MD 21852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gardens 5/23/00 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Final disaese or condition resulting in death) De fo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated examples.) Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1K Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy 217 No 1 Yes 1 ☐ Yas 2 ☐ No 25. Was casa raferred to medicel 26. Place of Death (Check only one) Other: 4 Nursing Home 52 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No

burial-transit The law requires that the death certificate be executed physician and Records, P.O. Box 68760, Physician/Medical use as the signed t p Completed certificate Division of Vitai or Attending Physician: Be Medical Certification: To this After death. within 24 hours after death.
To the Funeral Director: A completely filled in by the fi

27. Manner of Death

1/2 Natural 2 Accident

3 Suicide

29e. Certifier (Check only one)

4 Homicide

31. Date filed (Month, Oay, Year)

MAY 2 5 2000

5 Pending invastigation

6 Could not be determined

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural; or itema 23a or 23a-f ahow any Injury or other traumatic event, tra section Exempton mantal an pottled as

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0020

To the I within 2.

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

28c. Injury at Work?

28a. Date of Injury (Month, Day Year)

1 Yes 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

28d. Describe how injury occurred

Salisbury

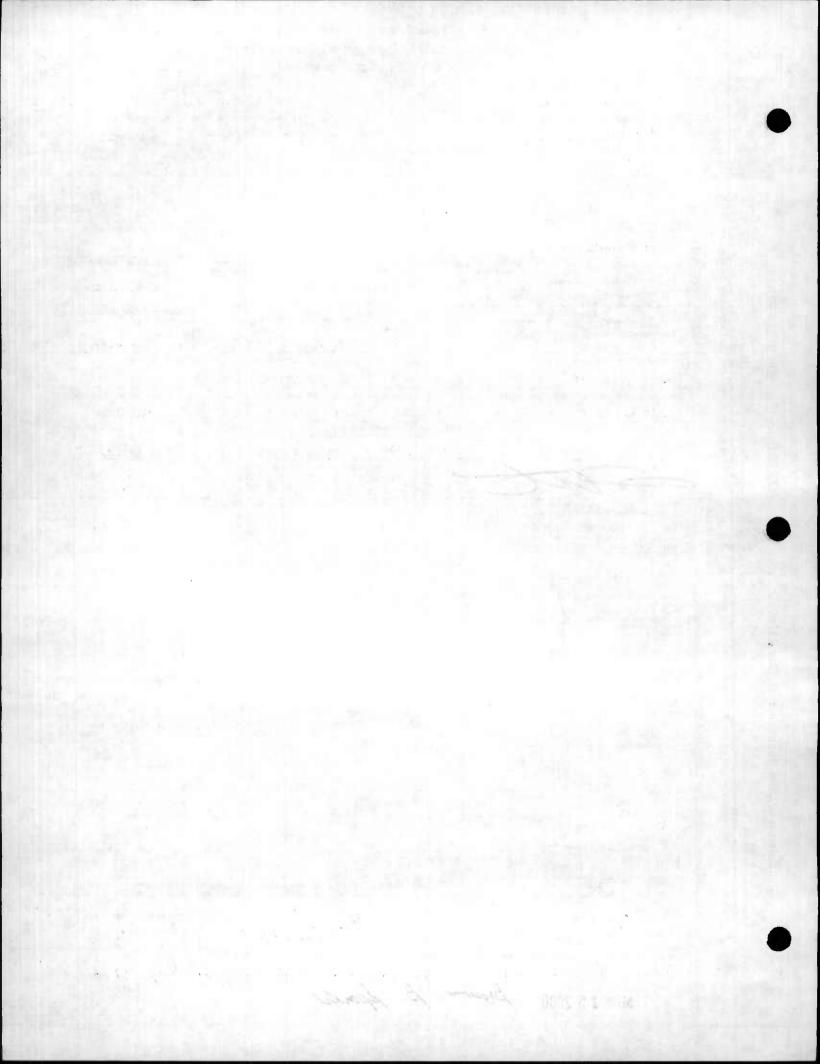
ess of person who completed cause of death (Item 23a) (Type, Print)

145 JOS-EPH Grasso M.D. E.

Carroll St., Suite A-1

28b. Time of

28e. Place of Injury - At homa, farm, streef, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Last) 2. Date of Deeth 3. Time of Death Month Year **Physician** Vernon Hinze Diers June 1. 2000 3:45am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chestertown Nursing & Rehab Center Chestertown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | October 7, 1913 6. Sex 1 M 2 □ F 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 86 Yrs. 535-10-7769 **Director** Oregon Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits tem 27 is marked other than "naturer, or items 23s or 28s-f show other traumetic event, the Medical Examiner inside be notified at XYes 2 No Directo Maryland Kent Chestertown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 402 Morgnec Road Apt 8D 21620 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 15 Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Maritel Status Bieck, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumetic event, the Mexicologics. Elementary/Secondary (0-12) Cottege (1-4or 5+) 12 Quality Control Engineer Electrical Engineer 18. Mother's Name (First, Middle, Malden Sumame) 17. Fether's Name (First, Middle, Last) Be Carrie Hinze Henry Diers 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Catherine Diers 402 Morgnec Road, Apt 8D, Chestertown, MD 21620 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State Old Bohemia Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6/5/2000 Middletown, DE 22. Name and Address of Fecility 21. Signature of Funeral Service License Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Pert1. Enter the disease, or *complications* thet caused the deeth. Do not enter the *mo*de of dying, such as cardiac or respiratory errest, Approximate shock, or heart failure. List only one cause on each line. **Physician** fmmediate Ceuse (Finel disease or condition resulting in deeth) Hypoplastic Myelodypplasia /Medical 15 montes **Examiner** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that inflieted events resulting in death) Last buriel-tren Due to (or es e consequence of) Physician/Medical Due to (or as a consequenca of) use as t Po Part tf. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 PUnknown CADZ / SIPCABG/ HXMI/S/PAAA Repair þ 8 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy HTN / 4 Chol 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: Other: 4th Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Tnpatient 2 ER/Outpatient 3 DOA 28b. Time of tnjury 27. Menner of Deeth Date of tnjury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a, Certifier 10 Certifying Phyefclan: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

The law requires that the deeth certificate be axecuted Records, P.O. Box 68760, Division of Vital

the Marylend

filed within 72 hours after

Baltimore, Maryland 21215-0020

the attending physician hed for use as the bune 2 • Hospital or Attanding Physician: 24 hours after death. • Funeral Director: After this certifica filled in by To the Hosp within 24 hor To the Fune completely fi

Medical 8 + 1

29b. Signeture and title of certifier

29c. License number

29d. Dete signed (Month, Day, Year) 06-01-0

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)

Neil Stoddard 100 Brown STreet, Chestertown, Maryland 21620 31. Dete filed (Month, Day, Yeer)

State Registrar

**JUN 02** 

32. Registrar's Signature

JUN 0.5 5000 John

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Amend# 19A 6/6/00 cmh AACO Health Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** June 6:00 p.m 19ene 4, 2000 /Medical 4a Facility Name((1) not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth NOV 7, 1921 If Under 24 Hrs. . Social Security Number 494-14-5860 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country)
Kansas **Funeral** Months Days 1 XM 2 F Hours Director Usuat Residence of Decedent deeth with the Maryland 10a State 10h County 10c. City, Town or Location r 28a-f show inotified at 10d. Insida City Limits 1 ☐ Yes 2 No Director NC Dare Frisco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nt of Health end Mental Hygiene.
If item 27 ie marked other than "natural", or items 23a or or other traumatic event, the Madical Examinal must be to order traumatic event, the Madical Examinal must be to other traumatic event, the Madical Examinal must be to other traumatic event, the Madical Examinal must be to other traumatic event, the Madical Examinal must be to other traumatic events. 27936 USA 201 Free Booters Court Funeral 12. Was Decedant Ever in U.S. Armed Forces? 1 1 Yes 2 □ No WW. If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etfiled within 72 hours efter WWII 1 ☐ Never Married 2 ☐ Married White Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify à 3 XWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Public Safety Elementary/Secondary (0-12) College (1-4or 5+) Fireman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be nent of Health end Mental Edwin Dyer Rosie May Bean 0 19a. Informant's Name/Relationship (Type, Print)

Joy Mullottl/ granddaughter 195 Maijor Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
122 Neptune Place, Annapolis, MD 21401 20a. Methodor Disposition Dyer/Son 20b. Place of Disposition (Name of June 9 20c. Location - City or Town, State natory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Elizabeth City, NC Department of Important: If eny Injury or New Hollywood Cemetery 2000 4 Donation 5 Other (Specify) 21. Signature of Furiefal Service Licen. Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 2 months disease or condition resulting in death) Examiner Examiner Umomni Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physiclan that the death certificate be Physician/Medical the Due to (or as a consequence of): 88 USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? be detached 1 No 2 No 3 Probably 4 Unknown Records, þ The lew requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s certificate hes 1 Yes 1 □ Yes 2 □ No of Vital or Attending Physician: 25. Was casa retarred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 topatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this funerel 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division s after de. "al Director: Afte Matural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nue Weine 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) Bostgate Road, Site 300, Amapoli, MD 21401 900 eanine 32. Hagistrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 6 2000

Registrar

Sec. 22.

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** · /Medical 4a Facility Neme 4b. City Town, or Location of Death 4c/ County of Death not Examiner HNADOLIS Under 24 Hrs 8. Date HUNADOUS 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 TF Director 214-74-6311 July 15,1906 Turkey Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified. 1☐ Yes RNo Directo Maryland Anne Arundel Annapolis 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1979 Baltimore U.S.A. Annapolis Blvd. 21401 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours efter. Constraint of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or feet in injury or other traumatic event. Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2€No Specify: Specify: White ð 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Meldan Surnama) Be Angelo Kosmides Athena Karides 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sotery Diamondides/son 417 Edgemere Dr. Annapolis, MD 21403 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Margarets Cem. 6/7/00 Annapolis, MD 4 ☐ Donetion 5 ☐ Other (Specify) ature of Funera 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cause at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of seath? 1 Yes 2 No 3 Probably by 24b. Wara autopsy findings available prior to 24a. Was an autopsy parformed? Completed completion of cause of deeth? 1 Yes 212 No 1 Yas 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Yeer) 27. Marylor of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending

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death with the Meryland

Maryland 21215-0020

Baltimore,

show

Certification: To

Medical

2 Accident 6 Could not be determined 4 | Homicide

3 Suicide

29a. Certifier (Check only one)

Investigation 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

**JEFFREY** 

critiving Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

Light the description of the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

29c. License number

29d. Data signad (Month, Dey, Year)

BRIGGS

M D

se of death (Item 23a) (Type, Print)

State Registrar

32. Registrar's Signature 0 6 2000

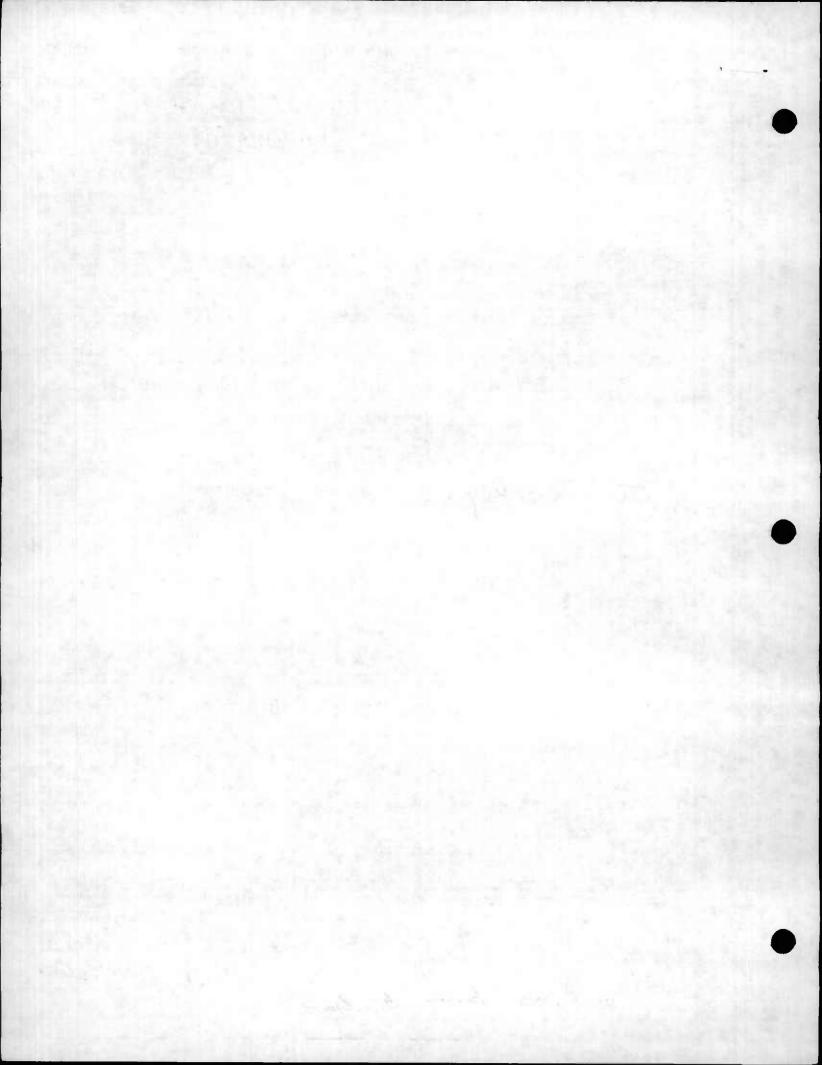
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Paysician   Models   Examiner   Security Name (in or institution, give a steret and rumpler)   See   Celly Town, or Location of Delath   Security of Deem   Securit	•	Amended #8, 06/02/2000, WCHD, HLC Certificate of Death  1. Decedent's Name (First, Middle, Last)		g. No.	3. Time of Death
Function  Society Southly Number  Losses To Country  Director  To Society Southly Number  Losses To Country  To Co	/Medical	Evangeline Davis	Month	21, 2000	03 50 AM
214-34-54/3 ITM stills 63 Vr. Mortis Days No. M. Mortis Days No. Days No. M. Maryland Wicomico Delmar  100 Elies and Vincomico Delmar  100 Zip Code  100 Z	Examiner	Johns Hopkins Hospital Bultin	nove City	BALTIM	ORE
Mary land Wicomico  Delmar  10.7 Sp. Gode  10.2 Pictore and Number  10.8 Sheller 10.0 Correy  10.8 Individual All Discontinum  10.8		214-34-5443 1 M 21 F 63 Yrs. Months Days Hours M	Min. (Month, Dey,	9. Bin 927 Pe	thplace (Stete or Foreign ountry) ennsylvania
The Martin State of the Company of t	show show sd.at	10a. Stele 10b. County 10c. City, Town or Location		,,,,	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
The work and the state of the s	or 28a-1 be notth	10e. Street and Number 10f. Zip Code	10	g. Citizen of What C	
Special Continues   Spec	death rms 23 r.mus r.mus	11. Merital Status  12. Wes Decedent Ever in U.S. Armed Forces?  1 □ Never Merried  12. Wes Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Sive  1 □ Yes 2 ☑ No If Yes, Sive  1 □ Yes 2 ☑ No If Yes, Sive	7 (Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
17. Fabrar's Name (First, Mode), Last)   18. Moharis's Name (First, Mode), Martha I. Morris's Name (First, Mode), Name (First, Mode), Martha I. Morris's Name (First, Mode), Name (F	ne. han "natura a Medical E mpleted	Elementary/Secondary (0-12) College (1-4or 5+)		6b. Kind of Business	/Industry
Louis Charles Garland  Martha I. Morris  199. Melling Address (Street and Number or Plural Plate Number, City or Town, State, 2p Code)  190. Melling Address (Street and Number or Plural Plate Number, City or Town, State, 2p Code)  191. Tomahawk Terrace - Middle River, MD 21220  200. Method of Disposition  180. Busing Address (Street and Number or Plural Plate Number, City or Town, State, 2p Code)  191. Tomahawk Terrace - Middle River, MD 21220  200. Method of Disposition (Specify)  210. Spratfungle Furnal Sanctes Losses  192. Spratfungle Furnal Sanctes Losses  193. Spratfungle Furnal Sanctes Losses  194. Spratfungle Furnal Sanctes Losses  220. Place of Disposition of Losses  231. Spratfungle Furnal Sanctes Losses  232. Part I. Enter the disease, or completenes that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest.  100   100   100   100   101   102   103   104   105   105   105   106   107   107   108  108					cation
Lamont L. Davis   Son   19 Tomahawk Terrace - Middle River, MD   21220	Menta arkad attc av				7122
20e. Method of Disposition 1 Dete 20c Localition - City of Town, State complete, commentary comments of comments o	Tis m traum				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contribute to the cause of	/Medical Examiner	JOLLEY MEMORIA  23a. Part1. Enter the disease, or complisations that caused the deeth. Do not enter the mode of dying, such as car shock, or heart feiture. List only on pause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	AL CHAPEL	st.	Aryland Ilisbury, MD 21801 Approximate Interval Between Onset and Death Uminutes 5 years
25. Was case referred to medical examiner?   25. Was case referred to medical examiner?   26. Place of Death (Check only one)	igned by the ettendin be detached for use by Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Stage II mixed mullenan tymor of the	1 Ye	autopsy 24b.	le to the cause of death?  Probably 4 Unknown  Were autopsy findings available prior fo
25. Was case referred to medical examiner?   1	e 2 sho	VILIVS .	_ periorii	1801	completion of cause
27. Menner of Death   Sea. Date of Injury   28b. Time of   28c. Injury at   28d. Describe how injury occurred   28d. Describe how injury o	icate i	OF We are referred to medical	/ /		1 ☐ Yes 2,2 No
30, Name and address of person who completed cause of death (Item 23a) (Type, Print)	s certification direction Be	examiner? Hospital: Other:			ecify)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	or: After thi the funeral cation: T	27. Menner of Death   Sex   Natural   Sex   Pending   Pending   Natural   Sex   Pending   Natural   Sex   Pending   Natural   Sex   Natural   Natu			
M Jan Holuff, MD RES-000 May 21, 2000	s after d al Direct ed in by	determined 286. Placa of Injury - At nome, farm, street, factory, office			Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	• Funeraletely fill	(Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death of			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To the comp	A	29	d. Date signed (Mor	nth, Dey, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  CYNTHIA JEAN HOLCOFT 600 N. Wolffe St., BALLMOYE, MD 21287	M	Inother Jean Holutt, MD RES-000	y Y	MAY 21.	2000
State Registrar  31. Date filed (Month, Day, Year)  MDY 3 0 2000  32. Register's Signeture  4. Inmany	State	Cynthia Jean Holcroft. 600 N. Wolffe St.	Baltimos	re, MD	21287 -

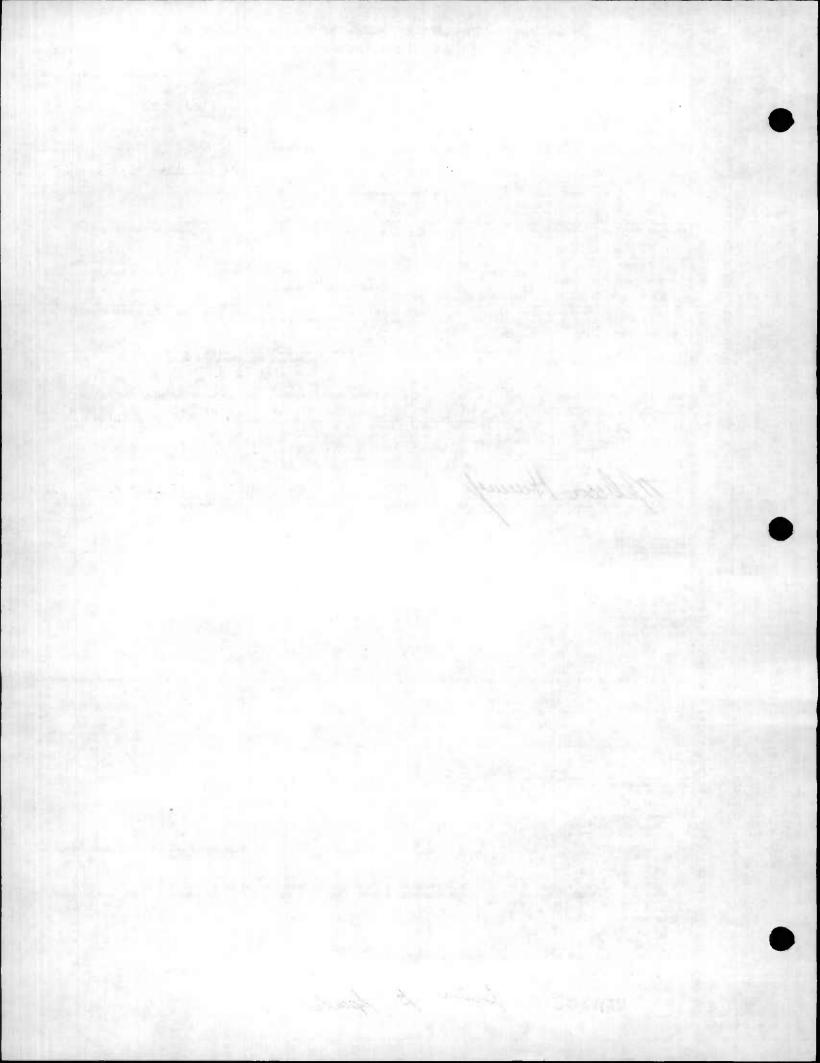


## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month **Physician** Monu.

May 423 2000

Death 4c. County of Death RUTH IRMA DAUBERT 2101 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO f Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F 051-12-4069 Yrs. Director 80 MAY 13, 1920 PENNSYLVANIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Nems 23a or 28a-f aho ner must be notified at 1 Yes 2 No Director MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 TROOPERS WAY 21804 U.S.A. Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Mexical Examples once. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM BENDER CLARA BOLLER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Reletionship (Type, Print) 5850 CUMBERLAND DR. SUZANNE SCHUMANN - DAUGHTER SALISBURY, MD 21804 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremation 3 ☐ Removal from State 5/25/00 CAMBRIDGE CREMATORY CAMBRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 705 E. MAIN ST. Jenne BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 23a. Party. Enter the disease, or complications that clased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. **Physician** immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Attending Physician: The law requires that the death certificate be axecuted for use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Due to (or es, a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by page 2 should be 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? peen completion of cause of death? 1 Yes 2 1 No 1 🗌 Yas 2 No After this certificate the funeral director, 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending investigation 1 Yes 2 No To the Hospital or Attendit within 24 hours after deeth. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) completely filled in by 4 Homicide 29e. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00054127 mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Delmen Hlon Davis 32. Registrar's Signature 31. Date filed (Month, Dey, Year) State MAY 2 6 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month May Dey **Physician** RADA 20, 2000 CATHERINE ELLIOTT 5AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SALISBURY CENTER: GENESIS ELDERCARE SALISBURY, MD. Wicomico If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1DM 2FF Days 214-10-6904 93 Yes February 10,1907 Director Maryland **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryle Department of Health end Meniel Hyglene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show with fujury or other treumstic event, the Medical Examinar must be notified at once. Maryland Wicomico 1 No Yes 2 No Salisbury Director 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 200 Civic Avenue 21804 IISA Completed by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 Yes 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Watson Shirt Factory 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be William Henry Lewis Della Kate Timmons 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Betty J. Morris/Daughter 112 Montleau Ave., Salisbury, MD 21804 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Mt. Pleasant Cemetery 5/24/00 Willards, MD 4 ☐ Donation 5 ☐ Other (Specify) M Funeral Service Licenses 22. Name end Address of Fecility m01051 Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 dompoor 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** ALENermen 3 Diserse Immediate Cause (Finel disease or condition resulting in death) /Medical CARS Examiner Physician/Medical Examiner ician and buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): å Due to (or as e consequence of) for use es Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by Colon CANCOR 1 Yes 2 No 3 Probably 4 Unknown þ page 2 should be 24b. Were autopsy findings available prior to Be Completed 24a. Was an eutopsy performed? peen completion of cause of death? certificate 1 ☐ Yes 2 No 1 Yes 2 No 25. Was cese referred to medicat examiner? 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 20 No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred

or Attending Physicien: The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending ringerowwithin 24 hours effer death.

To the Funerel Director: After this certifier

the Manyland

21215-0020

Baltimore, Maryland

CATHERINE ELLIOTT

RADA

State Registrar

Medical

1 Netural

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and little of

3 Suicide

29a. Certifier

5 Pending

investigation 6 Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WINR MD

NW

1104 HEALTHWAY DR., SALISBURY, MD 21804 32. Registrar's Signeture 72 3 2000

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

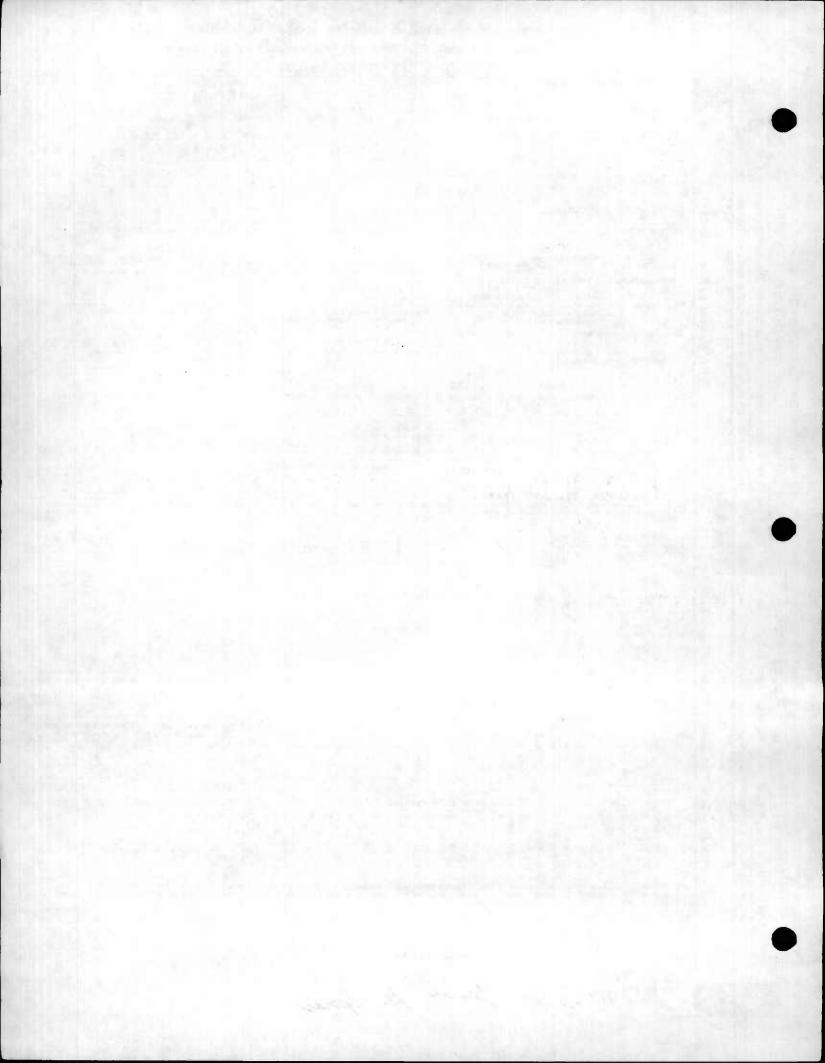
1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** CLARA ANN GRITZNER JUNE 2000 04. 10:20PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3748 BEACH DRIVE BLVD. **EDGEWATER** ANNE ARUNDEL H Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) SEPT . 29, 1923 If Under 1 Year 5. Sociel Security Number Birthplece (State or Foreign Country)
 ILLINOIS 7. Age (In yrs. last birthdey) **Funeral** Months Deys 1 M 2 F 493 20 7126 76 Yrs. Director Usuet Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director MARYLAND ANNE ARUNDEL EDGEWATER 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3748 BEACH DRIVE BLVD. 21037 UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Yeer or Detes: 14. Race - American Indien, Bleck, White, etc. 11 Maritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No ff Yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: WHITE Specify þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) College (1-4or 5+) HOMEMAKER HOME 17. Father's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middla, Maidan Sumame) Be (unknown) Hohrein (unknown) Hemmer 19a. tnformant's Name/Raletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) KATHY MEALY (DAUGHTER) 3748 BEACH DRIVE BLVD. EDGEWATER, MD. 21037 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donation 5 □ Othar (Specify) METROPOLITAN CREMATORY 6-5-00 ALEXANDRIA, VA 21. Signature of Funeral Service/Licensee 22. Neme end Address of Fecility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER MD 21037 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart feilure. List only one cause on each line. Physician Immedieta Cause (Finel diseesa or condition resulting in deeth) /Medical Lyears Las Cancer Examiner Dua to (or es a consequence of) Physician/Medical Examiner physician and the burief-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequance of): P.O. Box 68760, Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco was contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed to Records. ٥ 24b. Were autopsy findings available prior to completion of cause of daath? Completed 24e. Wes an autopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Hospital or Attending Physicien: director, Be 25. Wes casa referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Pesidance 8 Other (Specify) 1 Yes 2♥ No edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Death 28a. Dete of tnjury (Month, Dey Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturet within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Sulcide 6 Could not be detarmined 28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the causa(s) and mannar as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the causa(s) and menner stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the causa(s) and menner stated. 29a, Certifier (Check only one) To the 29b. Signetura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52830 Cenine weres my JUNE 05,2000 30. Name end address of person who completed cause of deeth (item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Jeanine 31. Dete filed (Month, Dey, Year)

JUN 0 6 2000

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werner, 900 Bestgate

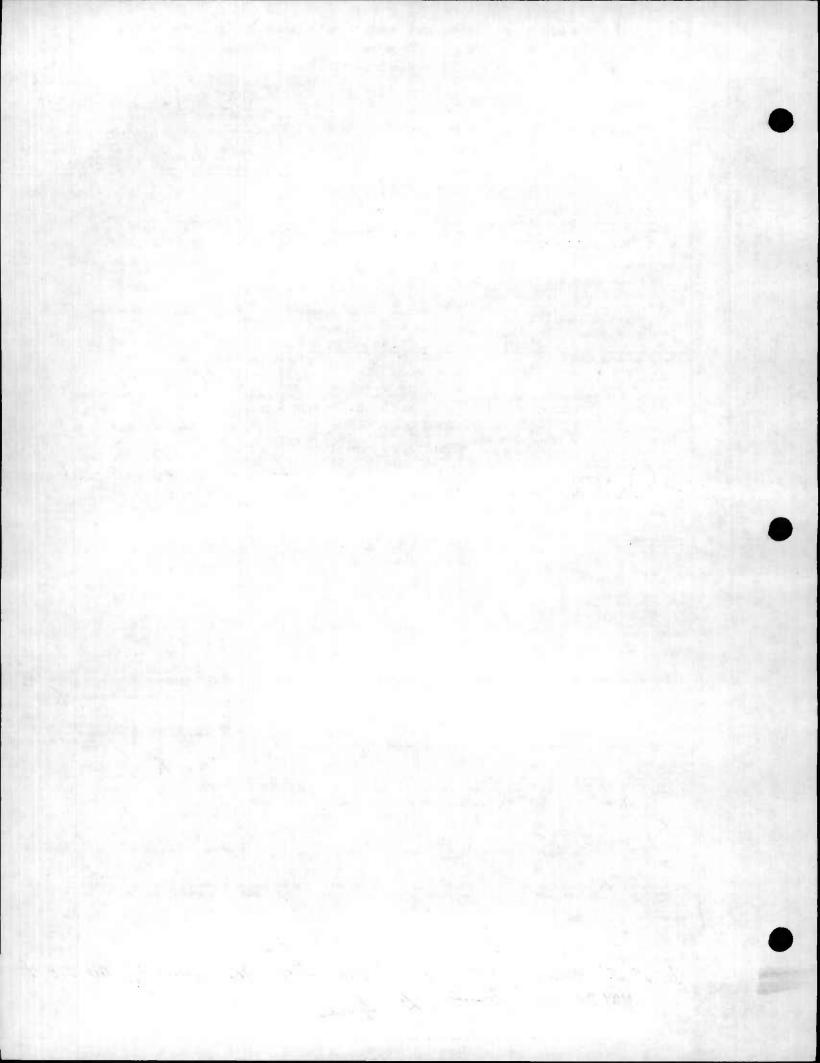
32. Registrer's Signeture

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ical	ALFRED	BU	RLIN		GRAF	TON	Month 5	2 Day	2000	0006
ner	4e Facility Neme (If not institution PENTINSTITA DE			T CEMET	20		or Location of Deat		inty of Death	
	5. Sociel Security Number	6. Sex							ICOMIC	Olace (State or Foreig
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arise coasts with the Maryand or Ners 23s or 23s-f show anyber, must be notified at y Funeral Director	10a. Steta 10b. County		11	Oc. City, Town	or Location				1	10d. Inside City Limita
	Maryland Wic	comico		Sa.	lisbury		1262	1X Yes		
	10e. Street and Number 6855 Mt. Verno		10f. Zip Code 21804				10g. Citizen of What Country? USA			
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To	19e. Informent's Neme/Relations Carol J. Graft				Meiling Address (Street 5855 Mt. Ve					
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been signed by the attending physician and should be detached for use as the burial-transit of the same should be detached for use as the burial-transit of the same shown is	23a. Part1. Enter the disease, or shock, or heart failura. List Immediata Cause (Finel disease or condition resulting in deeth)		t caused the each line.	ATIL	501 Snow of enter the mode of dyle on sequence of):	Hill Ro	d., Salis	bury, I		SSOCIATION 04 Approximate Interval Between Onset and Death
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	resulting in death) Last		Due		onsequence of):	ven in Part I.		tobacco use Yea 2□ N		o the cause of death bebly 40 Unknow
	resulting in death) Last  Part II. Other algnificant condition		Due		onsequence of):	ven in Part I.	1 🗆	Yes 2□Nessen autopsy ormed?	24b. W	./
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DHMH 16 Rav 6/95



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State of Maryland / Department of Health and Mental Hygiene 00 19352

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/Medical Examiner							4b. City, Tow	n, or Location of I	Death	4c. County	of Death			
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Funeral	5. Social Secur	ity Number	6. Sex 1 XM 2 ☐ F	T-10-10-10-10-10-10-10-10-10-10-10-10-10-	s. last birthdey) Yrs.	If Under Months	r 1 Year Days	If Under 24 Hrs. 8. Date of B Hours Min. (Month, D		of Birth h, Day, Year) 9. Birthpled Country		plece (Stete or Foreigntry)		
Director	215-62		-	47					OCT.	27,19	52	MD		
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be notified														
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r Items 23 instrmust Funeral	11. Marital Stat	tus	12. Was Dec	12. Was Decedent Ever In U,S. 13. Was Armed Forces?			Was Decedent of Hispenic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			No-	No- 14. Raca - American Indian, Bleck, White, etc.			
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To	CHESTER R. HADDAWAY  CONSTANCE G. CUMMINGS  19a. Informent's Neme/Reletionship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									5 0 3 4 1				
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127 14r tr	DEBRA M. HADDAWAY/WIFE PO BOX 189 TILGHMAN MD 21671													
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3,0	1 □ Burial 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify)  SPRING HILL CEMETERY						TERY	5-27-00 EASTON, MD						
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28	<b>►</b> M	F. News	nam	r cit	J				EIN & NE ST. EAS				HOME PA	
	23e. Part1. En	ter the disease, or heart failure. List	complications that	caused the de	ath. Do not en	er the mod	de of dyi	ng, such as c	ardiac or respireto	ory errest,			Approximate Interval Between	
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burial-transit al Examir	Sequentially lis	t conditions, to immediate		Due to	(or es e conse	quence ot):	:							
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e atte	Part II. Other si	gniffcant conditio	ne contributing to	death but not re	esulting in the u	nderlying o	cause gi	ven in Part f.	23b.	Did tobac	co use co	ntribute t	to the cause of death	
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40													~	
									24a.	Was en eu	ntopsy	24b. W	Vere autopsy findings vaileble prior to	
2 should										performed	7	C	ompletion of cause	
2 2										-		0	f death?	

Division of Vital R After this certificate h To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Coo

Medical Certification: To Be

25. Wes case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient XXER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) XXYes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 1 Naturel 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

29e. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, and due to the cause(s) and manner as stated.

XXMedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

MAY 25, 2000 O.C.M.E.

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

JACK M. Titus Mid 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signeture MAY 2 6 2000

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 035 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:15 am LILLIAN HUNT /Medical 4b. City, Town, or Location of Death 4c County of Death 4a Facility Name (If not institution, give street and number) Examiner 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Date of Birth Months | Davs | Hours | Min. | Months | Day | Hours | Min. 1414 LOG INN ROAD 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Days 10 M 20 F Yrs. Director JAN. 10 1925 MARYLAND 216-44-9768 Usuat Residence of Deced death with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits r than "natural", or Nema 23a or 28a-f ahov the Madical Exeminer must be notified at 1 ☐ Yes 2 No Directo MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1414 LOG INN ROAD 21401 USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Status Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2XXVo Specify: Specify: BLACK à 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) LAUNDRY SUPERVISOR US NAVAL ACADEMY 11th 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health end Mental Hy Important; if Item 27 is marked othe any Injury or other traumatic event Roka. Be CHARLES CROMWELL SR. KATIE HAYES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) THEODORE R. WATSON (GRANDSON) 1808 YAWL RD. ANNAPOLIS, MD. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Buriaf 2 ☐ Cremation 3 ☐ Removal from State ASBURY BROADNECK CEME. 6/9/00 ST. MARGARETS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 12. Leese MO0482 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ANNAPOLIS, MD. 21401. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** LUNG CANER Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examine attending physician and for use es the burial-trensit certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): Part If. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Ď Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificata has page 2 1 ☐ Yes 2 ☐ No 1 Yes 25. Was cese referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Naturat 5 Pending investigation 1 Yes 2 No A Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

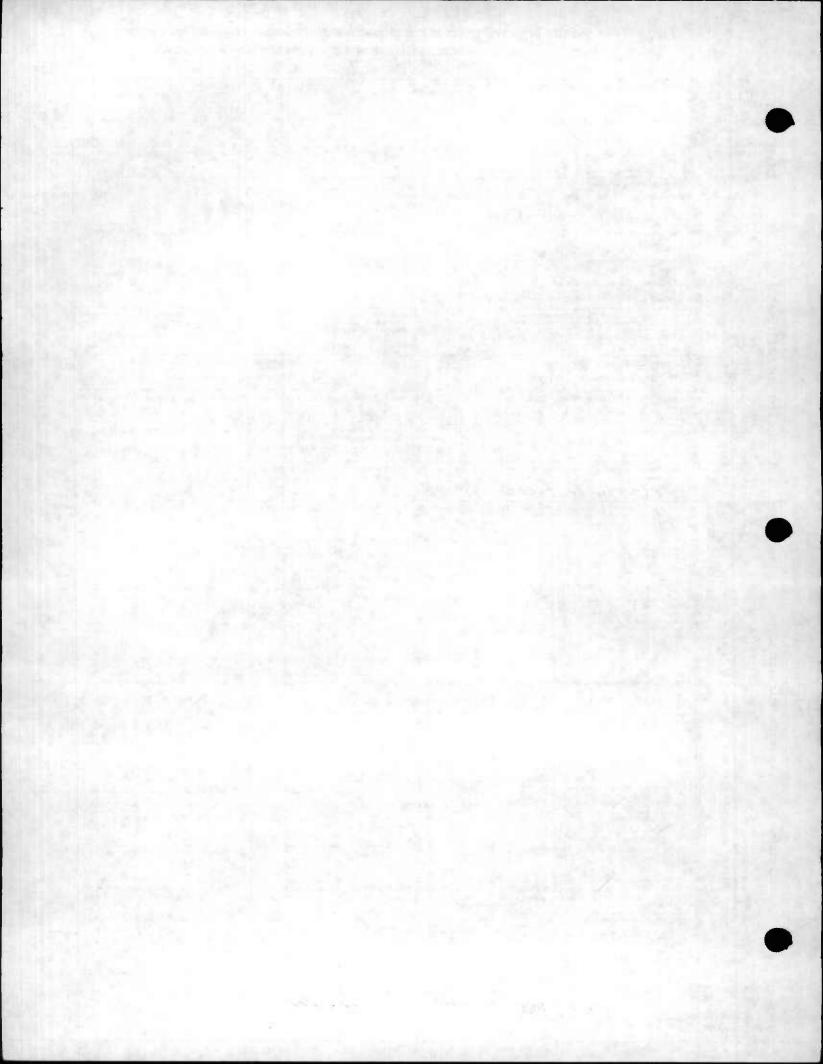
LONDED

JUN 0 8 2000

30. Name and address of person who completed cause of death (ttem 23a) (Type Birli)

Ro mo 32. Registrar's Signature 29d. Date signed (Month/Day, Year)

2000



#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2230 2000 DOROTHY ANN HENRY 02 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (St. Months | Days | Hours | Min. | SEPT. | 1, 1927 | MARYLAND 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 20 F 221-18-8688 Director Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No MARYLAND WICOMICO SHARPTOWN Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 405 WATER STREET 21861 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No t4. Race - American Indian, 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 6 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 2 3 ☐ Widowed 4 ☐ Divorced WHITE filed within 72 hours Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME other traumatic avant, permit. Peges 1 and 2 should be file Department of Haalth and Mental Hy important: If Item 27 is marked oths any injury or other traument 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) EDWARD LUTHER WHEATLEY NETTIE ELIZABETH ESKRIDGE 19a. fnformant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) ARTHUR E. HENRY/HUSBAND P. O. BOX 355, SHARPTOWN, MARYLAND 21861 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Steta 4 ☐ Donetion 5 ☐ Other (Specify) GALESTOWN CEMETERY 6/7/00 GALESTOWN, MARYLAND 22. Name and Address of Facility ZELLER FUNERAL HOME, P. O. BOX 207, 21. Signature of Funeral Service Licens 106 MAIN STREET, EAST NEW MARKET, MD 21631 Enter the disease, or commendations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feiture. List only one cause of machine. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner use as the bunal-transit Sequentially list conditions, If eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or trijury that initieted events resulting in death) Last Due to (or as a consequence of Physician/Medical Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Be Completed 2 XNO 1 ☐ Yes 2 ☐ No 1 Yas 25. Wes case referred to medical 26. Place of Death (Check only one) Medical Certification: To

The law requires that the death certificate be assecuted P.O. Box 68760 Records, of Vital Physician: After this Division or Attanding s after death. 2

28 N

Ã

21215-0020

Maryland

Baltimore,

Dorothy Henel

Hospital: 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes EDNa 27. Manner of Death Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. tnjury at Work? 28d. Describe how injury occurred 2 ☐ Accident 5 Pending investigation 1 Yas 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29d. Date signed (Month, Day, Year) 29c. License number

who completed cause of death (Item 23a) (Type, Print) Raffetto M.D. 005CPH

salisbury

State Registrar 31. Date filed (Month, Day, Year) JUN 0 7 2000

32. Registrar's Signature

within 24 hours

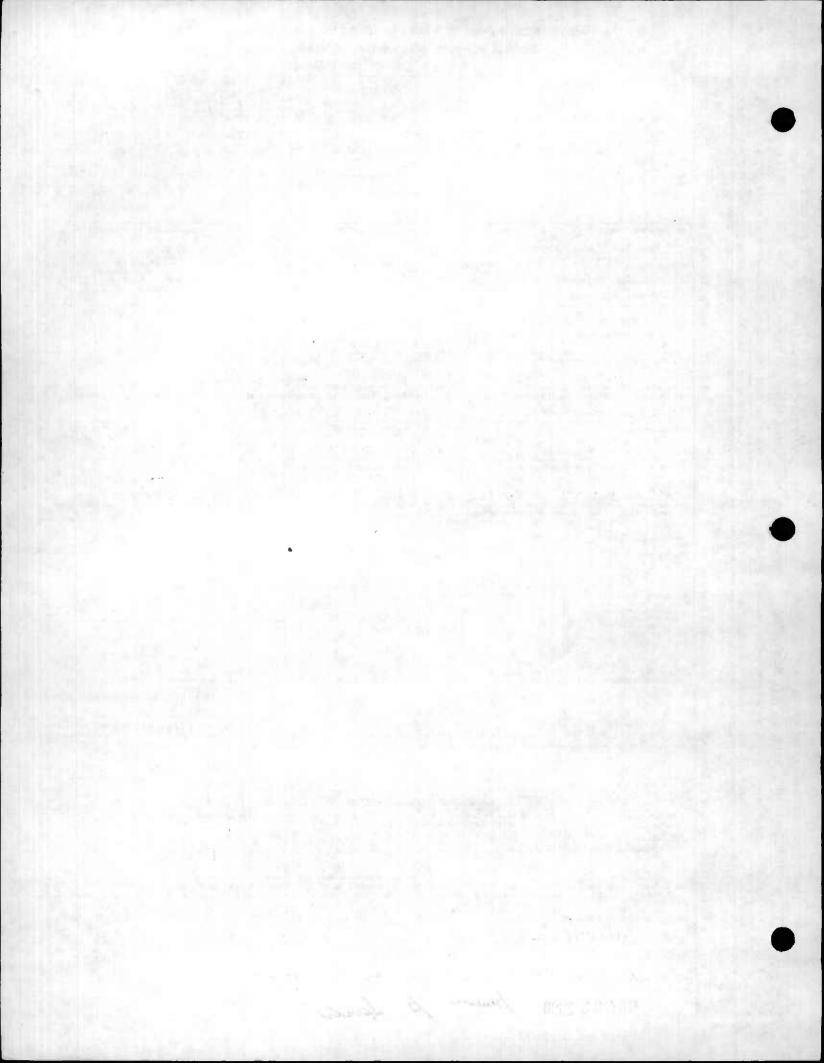
364 0 7 2000 Summer St. Speech

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		5 7/13/00 yg	C	Certificate o	t Death		Reg. No.	U	000		
Ada	1. Decedent's Neme (First, Middle	(Last)		-37	4 44	2. Dete of D		Year	3. Time of Dea		
hysician /Medical	William Robinso	n Honess	-45			MAY		3000	1528		
Examiner	4a Facility Name (If not institution,				4b. City, Town,	or Location of Dea	th 4c. County	of Death			
		IONAL MEDICAL	CENTER			BURY		OMICO			
Funeral Director	5. Social Security Number  165-40-8743  Usual Residence of Decedent	6. Sex 1⊠ M 2□ F 50	o yrs. last birtho	Months Dev		Min. (Month, D	rth ay, Year) 25, 1950	9. Birthple Count Penn	ece (State or Fo ry) sylvani		
B w	10a. State 10b. County	10	c. City, Town o	or Location				10	d. Inside City Li		
hours after death with the Maryans unst, or feens 23e or 23e-f show at Examiner must be notified at d by Funeral Director	DE Sussex		1 ☑ Yes 2								
	10e. Street and Number	•	10g. Citizen			ry?					
	Golden Meadows	Apt. # 82		1994	.0	U.S.A.					
	11. Merital Status  12. Wes Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Married In Yes Sign No If Ye			Wes Decedent of Hispanic Origin? (Specify Yes o     If Yes, specify Cuban, Mexican, Puerto Rican, etc.      □ Yes 2 ☑ No Specify:			or No- 14. Race - American Indian,				
	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	100 D	a a a da alla da la control O a c			40h Kind -40h	-1			
t, the Medical	15. Decedent's (Specify only highest	grade completed)	168. 0	ecedent's Usual Occ Give kind of work doi ife. DO NOT use ret	working	16b. Kind of Bu	Jsiness/Indi	ustry			
and die	Elementary/Secondary (0-12)	College (1-4or 5+)		tenance w			State o	f DA			
	17. Father's Name (First, Middle, L	ast)	Plain	iteliance w		Name (First, Middle					
Be C	Frank Charles H				1000	cet Robin					
To	19a. Informant's Name/Relationsh		10h A	Meiling Address (Stre				State Zin I	Codel		
4 2 2	Frank C. Honess			#1 Box 40				31818, ZIP C	,000)		
16	20a. Method of Disposition			isposition (Name of	JA DELI	Dete .		City or Toy	un State		
= 5	1 ☐ Burial 2 ☑ Cremetion	3 DRemovel from State	cemetery,	tery, crematory or other place)			20c. Location - City or Town, State				
(un)	4 Donation 5 Other (Sp.		Jambrid	lge Cremat		5-23-00	Cambrid	ge, M	ע		
ny ir	21. Signature of Funeral Service L	icensee //		22. Name end Add Short Fur		ne					
	William M. Stort 13 E. Grove St. Delmar, DE 19940										
	23a. Part1. Enter the disease, or complications that cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.										
sician	SHOCK, OF FIBER FEBRURE. CISCO	thy one cause on each min.							Interval Between Onset and Dea		
edical	Immediate Cause (Final										
miner	Immediate Cause (Final disease or condition resulting in death)  a. A cute myo conduit infarct, an Due to (or as a consequence of):  b. Coronary artery disease										
9		Due	to (or as a cor	nsequence of):				1			
m min		b. Coror	1904	artery	discare				403		
burlai-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):										
5 2	Cause (Disease or injury		1								
e the	resulting in death) Last										
	resolung in coauti, cast										
2	losoiting in coauty cast										
2	1950ring in Goduly Last										
2	Part II. Other significant condition	is contributing to death but no	nt resulting in th	ne underlying cause	given in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of d		
2		as contributing to death but no	x resulting in th	ne underlying cause	given in Pert I.						
gned by the ettending be deteched for use by Physician/M		ss contributing to death but no	ot resulting in th	ne underlying cause	given in Pert I.	12	Yes 2□ No	3 □ Prob	ebly 4□Un		
gned by the ettending be deteched for use by Physician/M		ss contributing to death but no	ot resulting in th	ne underlying cause	given in Pert I.	1 Z	_	3 ☐ Probe	ably 4 Uni		
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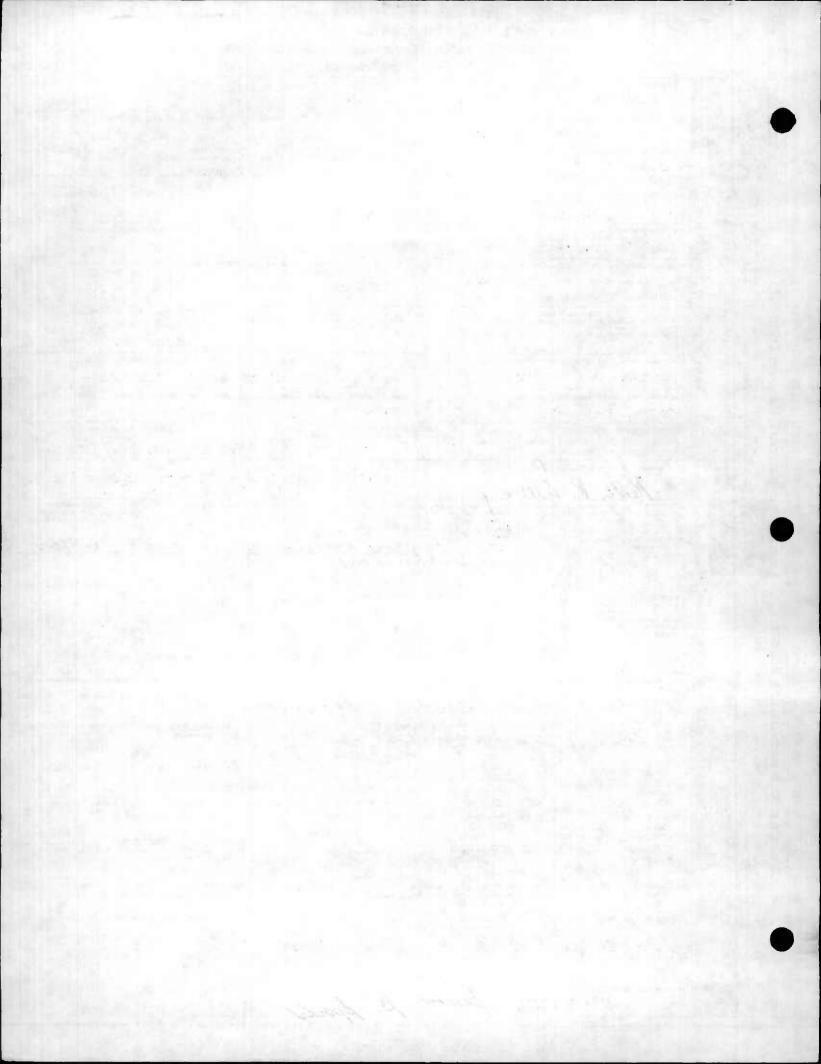
DHMH 16 Rev 6/95



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	141		OCH	ificate of	Dealii		Reg. No.		0 Time (0 1		
Decedent's Nama (First, Middle, VIRGINIA		NTON	Н	ANSON		2. Data of Dea Month May 1	Day 2000		3. Tima of Death  12:30 pm		
4a Facility Nama (If not institution, Wicomico Nu	•				4b. City, Town, or L Salisbut			of Death			
5. Social Security Number 218–48–6855	6. Sex 1 ☐ M 2 및 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birt (Month, Day September	ry, Year)		lace (State or Foreign try) th Carolina		
Usual Rasidance of Decedent  10a. Stata 10b. County		10c. City	, Town or Loc	ation		•			0d. Inside City Limits		
	1NVes 0										
10e. Street and Number	IIICO		Salisu	10f. Zip Code		10g. Citizen of What Country?			try?		
900 Booth Stre	eet				1		USA				
11. Marital Status  1 Nevar Married 2 Marrie	Armed For	12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No		13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R  1 Yas 2X No Specify:			14. Raci Blac	Race - American Indian, Black, White, etc.			
3 ☑ Widowed 4 □ Divorced  15. Decedant's (Specify only highest Elemantary/Secondary (0-12) 12	Yaar or Da	itas:	16a Danada	ette Heuri Occur	nation			Wh:	ite		
15. Decedant's Education (Specify only highest grade completed)  Elemantary/Secondary (0-12)  12  Collega (1-4or 5+)  4+			16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)  HOMEMAKET			16b. Kind of Business/Industry  Domestic			ostry		
17. Fathar's Nama (First, Middle, L.	ast)				18. Mother's Nam	a (First, Middle,	Maiden Surnam	e)			
Doctor Dee H	Benton				Lillia	n Alice Atkinson					
19a. Informant's Name/Ralationshi	19a. Informant's Name/Ralationship (Type, Print)  19b. Mailing Addrass (Street and Number or Rura										
Hugh K. Hanson	Son	201- 01			Salisbur	y, MD 21		City or To	um Ctata		
20a. Mathod of Disposition  1 □ Burial 2 XCramation 3  4 □ Donation 5 □ Other (Spe	ecify)	tata	isbury	ition (Name of atory or other pla Cremato	ry 5	5/22/00	Salisl				
22. Nama and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804  23a. Part1. Entar tha disaase, or complications that gused tha daath. Do not entar tha mode of dying, such as cardiac or respiratory arrest, interval Between Interval Between											
resulting in death)		Due to (or	aya consequ	ence of):				1			
Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last	b		as a consequ								
rasulting in death) Last	cd.	Due to (or	as a consequ	ence of):	ven in Part I	23h Did 1	lobacco usas con	ntribute to	the cause of death?		
rasulting in death) Last	cd.	Due to (or	as a consequ	ence of):	ven in Part I.  Description		Nobecco use cor Yes 2/3 No		the cause of death?		
rasulting in death) Last	d.  d.  d.  exactive (	Due to (or	as a consequ	ence of):	ven in Part I.  Depens	24a. Was perfo	Yes 2 No an autopsy med?	3 Prob	tre autopsy lindings allable prior to mpletion of cause death?		
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DHMH 16 Rev 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 9357 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Year Pau1 L. May 31, 2000 4:30 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 7102 Lois Lane Lanham If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 10 M 2□ F Months Days Hours Yrs. 217-01-8276 100 9/3/1899 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No MD Prinec George Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7102 Lois Lane 20706 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Delo If Yes, Give Year or Detes: 1 Never Married 2 ★ Married 1 Yes a No Specify: SpecifWhite 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Steam Fitter Refrigeration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert L. Ingram Lydia Jane Davis 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rheba I. Webb- daughter 381 Mill St., Fawn Grove, PA 17321 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State 1 □ Byrial 2 □ Cremetion 3 □ Removat from State 4 □ Donetion 5 □ Other (Specify) Darlington Cemetery 6/3/2000 DArlington, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Harkins F.H.Inc., 600 Main St., 11. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, hock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or sea consequence of): 7MIU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 □XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 \$\times\$ Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

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"natural", or items 23s

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked othwan any Injury or other traumatic avant PARS.

filed within 72 hours after

Saltimore, Maryland 21215-0020

the Medical Examiner must be notified at

Director

p

Completed

Be

Physician/Medical Examiner sician and burial-transit physician s the buria þ Be Completed Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica stely filled in by the funeral director. edical Certification: To

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signeture and title of certifie

The law requires that the death certificate be executed

Box 68760.

P.O.

Records.

of Vital

Division

To the Hospital
within 24 hours a
To the Funeral C
completely filled State

Registrar

this certificate

30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Kane, M.D. 4910 Massachusetts Ave., #304, Washington, D.C. 20016-4300 James

31. Dete filed (Month, Day, Year) JUN 0 5 2000

5 Pending Investigation

6 Could not be determined

32. Registrar's Signature

WENLE

28a. Dete of Injury (Month, Day Year)

28c. fnjury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

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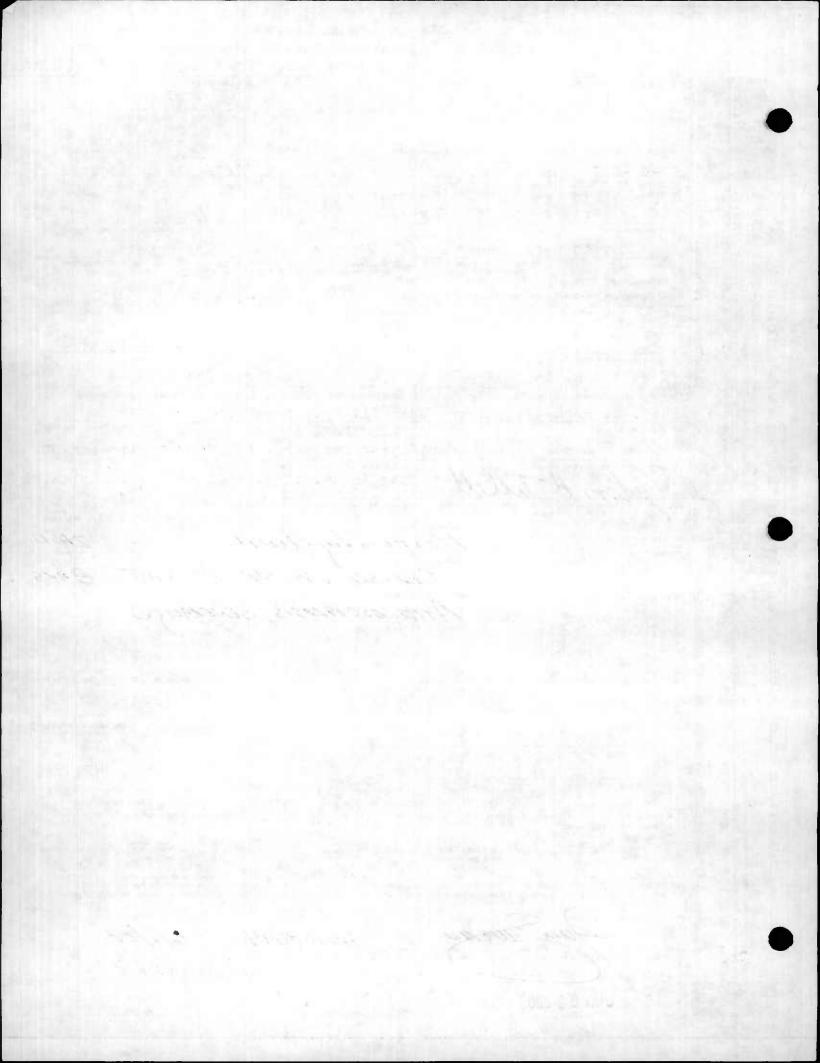
28d. Describe how injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1250 Month REBA EMA JONES 3 31 00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LOCH RAVEN CTR Towson Baltimore if Under 1 Year It Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1□M 20F 213-20-0871 Jan. 21, 1921 Maryland Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll Westminster 1 ☐ Yes 2€ No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3802 Wine Road 21158 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes À XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Biack, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Esther Ida Cosner Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie L. Huffman-daughter 3802 Wine Road, Westminster, Maryland 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gardens 6-3-00 4 Donation 5 Dother (Specify) BelAir, Maryland Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part . Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac of respiratory arrest, Abi nodon, Mary Land 21009 shock, or heart tailure. List only on clause on each line. tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Party. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobaccouse contribute to the causa of death? 1 N68 2 No 3 Probably 4 Unknown · Deas 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? OF THE 1 Yes 1 ☐ Yes 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinational teaching at

Hygiene.

permit. Peges 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any Injury or other traumatic event, ones.

with the Maryland

death v

filed within 72 hours efter

Baltimore, Maryland 21215-0020

Examiner

ettending physician and I for use as the burial-transit funeral

Physician/Medical þ Completed Be 2 Certification:

27. Manne of Death

1 Natural

2 Accident 3 Suicide

4 Homicide

31. Date tiled (Month,

29a, Certifier

certificate be executed P.O. Box 68760. signed by the peed certificate has Division of Vital this After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

> State Registrar

9

Medical

25. Was cese reterred to personal examiner? 1 Yes

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

5 Pending investigation 6 Could not be determined.

28b. Time of

1 Yes 28e. Place of Injury - At home, tarm, streat, tactory, office building, etc. (Specify)

28c. Injury at Work? 2 No

26. Place of Death (Check only one)

28d. Describe how injury occurred 28t. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Noticing Home 5 Residence 6 Other (Specify)

😰 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

290. Signature and title of certifier an'co kg

29d. Date signed (Month, Day, Year) HARFORD PUAD

MARYLARED 2/234

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 8903 786 cito

ATRIGO 32. Registrar's Signature

BA 67

**DHMH 16 Rev 6/95** 

## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

					arylari	•	tificate of	Death	Wiering Try	Reg. No.	עפטעו			
	Physici	an	1. Decedent's Name (First, Middle, L						2. Date of De Month	eath Day	3. Time of Death			
1	/Medic		AMBROSE JEAR						JUNE 4	1	10:45 pm			
	Examir	_	4e Facility Name (If not Institution, g					4b. City, Town, or	Location of Deat	h 4c. County	of Death			
			GENESIS ELDER ( 5. Social Security Number 6.			EK last birthdey)	If Under 1 Year	NNAPOL If Under 24 Hrs	IS 8. Date of Bi		ARUNDEL			
	Funeral Director		215-38-7677 Usual Residence of Decedent	1M 2□F	82	Yrs.	Months Days	Hours Min		ay, Year)	9. Birthplace (Stete or Foreign Country) N. CAROLINA			
	pung and		10a. State 10b. County		10c. City	y, Town or Loc	alion		90.07		10d. Inside City Limits			
	Many	io lo	MARYLAND ANNE	ARIINDET.	AMN	NAPOLI	S				1 ☐ Yes XIXNo			
	7.28e	Director	10e. Street and Number	IKOKDED	11141	THE OBL	10f. Zip Code			10g. Citizen of W	/het Country?			
death with the Maryland ime 23a or 28=4 show remails a notified at neeral Director			930 BAY FOREST	CT. APT.	319	)	2140	)3	40.0	I	USA			
	Herme Herme	Funeral	11. Marital Status 12. Was Deceden Armed Forces					fispanic Origin? (: an, Mexican, Pue	Specify Yes or Norto Rican, etc.)		e - American Indian, k, White, etc.			
urs a		by	1 Never Married 2 Married 3XXVidowed 4 Divorced	YOXYes 2□	s 2 □ No						black			
2-0	72 ho	eted	15. Decedent's 8 (Specify only highest g	ducation		16a. Deced	ent's Usual Occup	ation duning most of we	orkina	16b. Kind of Bu	siness/Industry			
21	ithin	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	O NOT use retire	during most of wo						
	al Hygier other ti vant, th	S	12th	0		C	OOK	10 Mothada Na	ma /Finat Middle		AL ACADEMY			
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2	should nd Men marke imatic	2	HOLIDAY JEA			10h Mailin	Addrage (Straat		STEVENS ural Route Number, City or Town, State, Zip Code)					
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ē,	Heal Heal Herr 2 other		20a. Method of Disposition	(5011)	20b. P	lace of Dispos	ition (Neme of		Date		City or Town, State			
9	Pages nent of rnt: If its rry or o		HDXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				etory or other ple VETERA		6/0/00	CDOWNER	WILLE MD			
altimore,	artmer ortant: injury		21. Signature of Funeral Service Lice		PIAP		Name and Addre		0/9/00	CROWNS	VILLE, MD.			
ñ	Deg and a grand		Mary 13	Leese 1	400					TUARY, I				
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl	nplications that cause y one cause on each I	d the deeth	h. Do not ente	r the mode of dyi	ng, such as cardia	c or respirelory	errest,	Approximate Interval Between			
	Physician /Medical		Immediate Course (Final		^						Onset and Deeth			
	Examiner		Immediate Ceuse (Final disease or condition resulting in death)  a. Aorticanewysm											
		- e	Due to (or as a consequence of):											
	unsit	edical Examiner		b	D /a									
,	n end	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Ceuse (Disease or Injury c.											
68760	icate be executed physician end s the bunal-transit	Cal	Cause (Pisease or injury  Cause (Disease or injury  that initiated events  Due to (or as a consequence of):											
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ŏ	th cell	Se		d							I			
P.O. Box	he att	Physician/M	Part II. Other significant conditions	contributing to death t	out not resu	ulting in the un	derlying cause gi	ven in Part I.	23b. Did	tobacco use con	ntribute to the cause of deeth?			
<u>Р</u>	d by t	Phy							1□	Yes 2□ No	3 Probably Sunknown			
ds,	The law requires that the death certificate be executed to has been signed by the attending physician end page 2 should be detached for use as the bunal-transit		72-2-								Odb Ware subserville day			
0	neen	etec								s an autopsy omed?	24b. Were autopsy findings available prior to completion of cause			
Records,	has b	Completed by			_						of deeth?			
									10	Yes No	1 ☐ Yes 2 ☐ No			
Vital	Physicien: The law rithis certificate has be ral director, page 2 s	o Be	25. Wes case referred to medical exeminer?	Hospitel:	The		oD = a · Oti	201	eath (Check only					
ō		1: To	1 ☐ Yes ♣ PNo  27. Manner of Death	1 Inpati		ER/Outpatient 28b. Time of	3□ DOA 28c. Inju			how injury occurr				
Division of	Afte fund	to	1 Accident 5 Pending investigeti	28a. Dete of Inju (Month, De	y Year)	Injury		rk?  Yes 2 □ No						
18	I or Attending Physister death.  Diractor: After this in by the funeral di	fice	3 ☐ Suicide 6 ☐ Could not	289. Place of in	28e. Place of Injury - At home, farm, street, fectory, office 28f.					(Street and Numb	er or Rurel Route Number,			
ā	Die of	Certification:	4 ☐ Homicide	building, e	tc. (Specif)	y)			City or 16	iwn, Stete)				
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera	edical		hysician: To the best miner: On the basis of and manner st	f examinat						unner as stated. and due to the cause(s)			
	Vithin Fo th	Me.	29b. Signature and title of contifier	7- 3-40-3-			29c. Licens	se number		29d. Dete signed	d (Month, Dey, Year)			
			1201	Come			0.3	2030	2	6/6	100			
			30. Name and address of person who	completed cause of		23a) (Type, F	Print)	Clara	Lu on	29d. Dete signed (6/6) 2-16	19			
	Sta	10	31. Date filed (Month, Dey, Year)	32. Regist		ture b	A AN COM		( )					
E	Registr	-	JUN 08	. 6.	present	19	Book	the						

DHMH 16 Rev 6/95

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 360 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Yee **Physician** bsen 2000 MA 31 /Medical 4c. County of Death 4b. City, Town, or Loc ation of Death Facility Name (If not institution, give street and number) Examiner Olev Burnie 1+A1 Age (In yrs. last birtho If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Oct 20, # Under 1 Ye Months Da 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 180 M 2□ F 69 365-30-1075 Director Michigan Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examinal must be notified. 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Anne Arundel MD Severna Park 1 Yes 2 No Directo 10f. Zip Code 21146 10g. Citizen of What Country? 10e. Street end Number 183 Grosvenor Lane USA Funeral 12. Wes Decedent Ever in U.S. Amed Forces? 1 Yes 2 No 195 If Yes, Give 197 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritel Status 1952 1 Never Married 2 Merried White altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify py 1979 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Coast Guard Elementary/Secondary (0-12) College (1-4or 5+) Officer 18. Mother's Name (First, Middle, Malden Surname) Licile Kenney 17. Father's Name (First, Middle, Last) Be Axel Victor Jacobsen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 183 Grosvenor Lane, Severna Park, MD 21146 19e. Informent's Name/Relationship (Type, Print) Sheila Jacobsen/wife 20b. Place of Disposition (Neme of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition June 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, VA Arlington National Cem. 2000 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home MD 21146 495 Gov. Ritchie Hwy., Severna Park, nef the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, rheart feilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Myocardial Infarction /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last and Due to (or es a consequence of): physician a s the bunal-t Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequenca of): attanding p signed by the a ld be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 24b. Were autopsy findings available prior to completion of cause of death? should ! Completed 24e. Wes an autopsy has la 2 cartificata hadirector, paga 2 1 Yes 21 No 1 Yes 2 No : After this cartification a funaral director, or Attending Physician: 25. Was cese referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 1 Natural 5 Pending daath. 1 ☐ Yes 2 ☐ No Investigation 2 Accident within 24 hours after death To the Funeral Director: / complately filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homloide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. Medicai (Check only one) Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

JUN 0 6 2000

me and address of person who comple

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

im. 32. Registrar's Signature

put

red ceuse of deeth (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Moeth, Day, Year)

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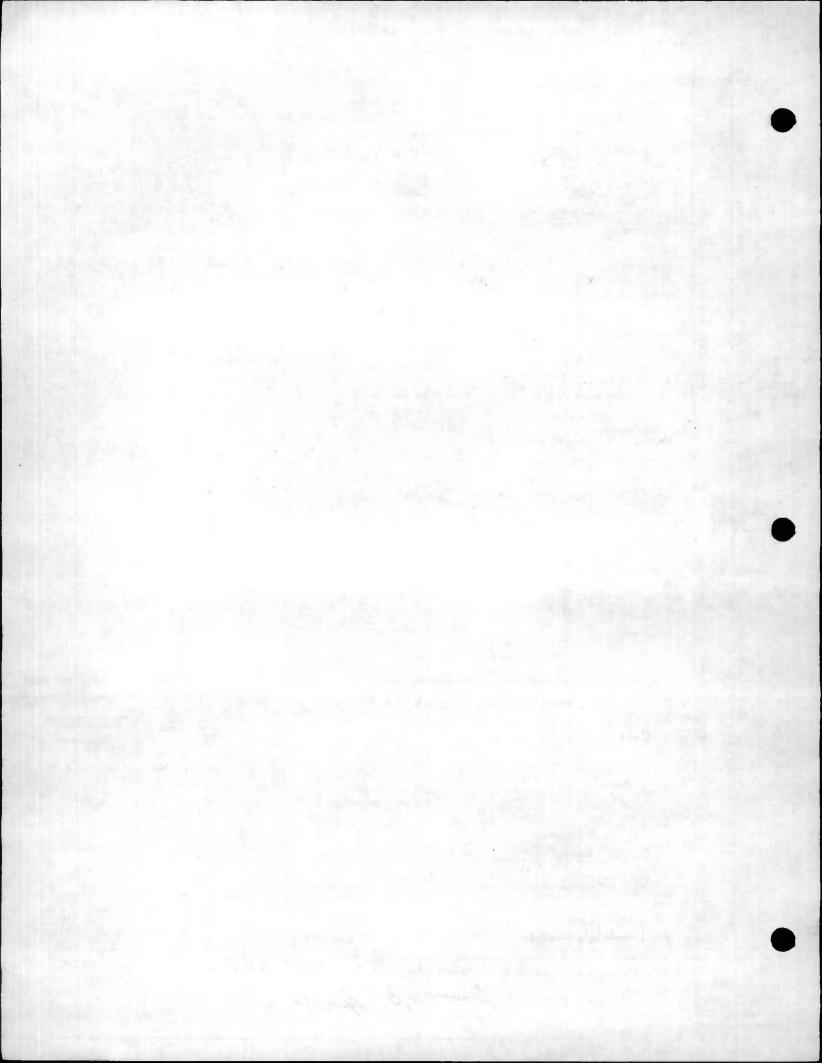
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Still builted and all

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1936

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		's Nama (First, Middle,	Last)					2. Data of D		Yaar	3. Tima ol Death
Physicia /Medic	NA C TT	in Elzy	Jerniga	in				MAY	26, 2v		2225
Examine	An Capilla N	lame (If not institution,	give street and numb	oer)			4b. City, Town,	or Location of De	ath 4c. Cou	nty of Death	
100	PEI	NINSULA REC		ICAL CE	ENTER		SAL	ISBURY	W	ICOMIC	20
Funeral	5. Social Sec	curity Number	6. Sex. 1 M 2 F 7.	Age (In yrs. la	st birthday)	If Under 1 Ye		Irs. 8. Data of E	lirth	9. Birth	place (State or Foreign
Director		0 3113	124 M 2LIF	63	Yrs.		175	lin. B. Data of E. (Month, L. Aug. 3	1936		yland
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h the Marylen r 28a-f ehow											1 Yas 2 □ No
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20		or Married 2 Marrie	If Yes, Give		10	Yes 2X	No Specify:		Spe	city:	
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Baltimo Baltimo pemit. Page Department: Important: If eny injury or	21. Signatur	e of Funeral Service Li	icensee	144	22.	Nama and Ad	dress of Facility Funera				
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Paris in the state of the state	resulting in d	eath) Last		Due to (or a	as a conseque	ince of);					
X centification of the centifi	2		d								
Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate best signed by the ettending physician and in by the funeral director, page 2 should be deteched for use as the buriel-transit.	Part II. Other							W			
O # ##	Part II. Other	significant condition						23b. Di	d tobacco use	contribute (	o the cause of death
Division of Vital Records, P.O. or attending Physician: The law requires that the effect death.  Director: After this certificate has been signed by the timeral director, page 2 should be detected.	£ S	firure, H	instaged	ar. D	astrdon	will.	, amb.	10	Yes 2□N	o 3 Pro	bably 4 Unknow
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0 4 4	27. Manner o		28a. Data of I (Month,	Injury 2	28b. Tima of	28c. I	njury at Work?	28d. Describe	how injury oc	curred	
din din	0 1 ⊠Natur 2 □ Accir	1		Day rear)	Injury		1 Yes 2 No				
Amender de de de de de de de de de de de de de	3 ☐ Suic		and 200. Place of	Injury - At hon	na, farm, stree	t, factory, off	ice			mber or Rur	al Routa Number,
D Para	4 ☐ Hom	icide	building,	, etc. (Specify)				City or I	own, Stata)		
DIVISION Of VITAL Re to the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	27. Manner o 1 Manner	12 Certifying	Physician: To the be	st of my know	ledge, death o	ccurred at th	e time, data and pla	aca, and dua to th	a causa(s) and	mannar as	stated.
Hod 124 h	(Check o	nly 2□ Medical E	marniner: On the basis	s of axamination	on and/or inve	stigation, in n	ny opinion, death or	ocurred at tha time	a, data and place	e, and dua t	to the cause(s)
did of	≥ 29b. Signatur	re and title of certifier		JIELOG.		29c. Lic	cense number		29d. Data sig	ned (Month.	Day, Year)
F 3 F 8		Was and	000				6612 (M	10.	5 2		
							2016		, -		
		d address of person w	ho completed cause of	of death (Item 2	23a) (Type, Pi	int)	- dela	MO 7.80			
		Crouch HO					יכויוף השליום	1.00 5.001			
State	<u> </u>	(Month, Day, Year)	32. Reg	istrar's Signatu	ire A	So	- 11 .				
Registra	r	MAY 3 (		-	1.	1601	Bella!				

DHMH 16 Rev 6/95



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Susie Jackson 24, 2667 4c. County of Death 2236 May 4b. City, Town, or Location of Bath 4a Facility Name (If not institution, giva street and number) PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) June 26 1920 Maryland 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Days 1 M 2 F Yrs. 217-28-3388 79 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 824 South Shoemaker DR.Apt.104 U.S.A 21804 12. Was Decedent Ever in U.S. Armed Forces?. 1 Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Bace - American Indian Black, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Domestic None 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Charles Jackson SR. Daisey Townsend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1010 S.Delano Ave.Salisbury Md.21801 Leigh Jackson (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Mem. Garden / 100 Hebron, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801 29a. Part 1. Entar the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Bornot enter the mode of dying, such as cardiac or respiratory arrest, Approximata Intarval Batween Onsat and Death Immediata Cause (Final diseasa or condition resulting in death) 25+108 Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last que to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Ware autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 No 1 🗆 Yas 1 ☐ Yas 2 ☐ No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 1₽¶npatient 2□ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Natural

Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed physician is the burial Box 68760, P.O. | signed by the betack Records, page 2 should Vital certificate director, this After

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

238

or Items

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy,
Important: If item 27 is marked other
any injury or other traumatic events.

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-002

Directo

Completed

8

þ Be Completed Certification: To Medicai

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

or Attending Physician: Division of To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After completely filled in by the fun

State Registrar

29b. Signature and title of contilion

5 Pending investigation

6 ☐ Could not be detarmined

29c. License number D 55658

12 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, end due to the cause(s) end mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

1 Yas 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

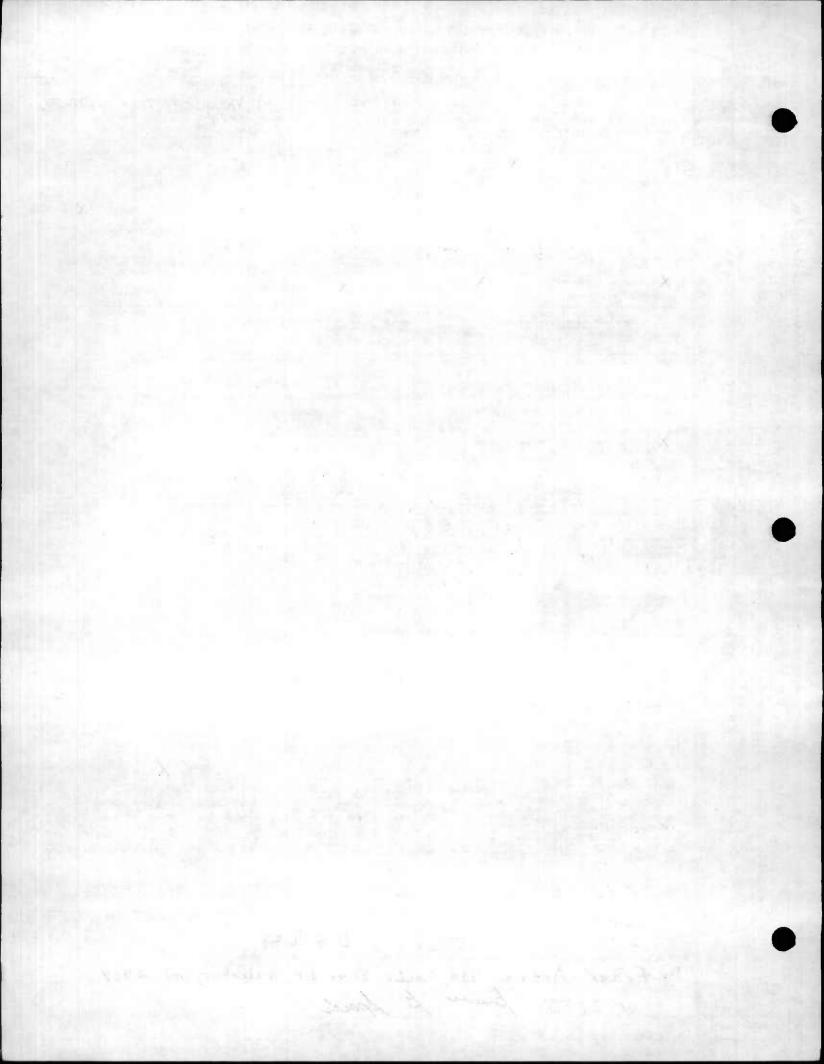
30. Nema and address of person who completed cause of death (ttem 23a) (Type, Print)

Shore Dr. Salisbur, md. 21504 Frank Arena 400 Eastern 31. Date filed (Month, Day, Year)

MAY 2 6 2000

32. Degistrar's Signature

28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify)



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 30 CO 10:11 PM Charles Leager /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner Maryland Medical Baltimore Baltimore System University of 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth

79 Yrs. Months Days Hours Min. February 24, 1921 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Country)
Price, MD 5. Social Security Number **Funeral** 217-36-0901 Director Usual Residence of Deceden 10d. Inside City Limits 10b County 10c. City. Town or Location 10a State or flams 23s or 28s-f show 1 ☐ Yes 2 No Maryland Queen Anne's Funeral Directo Church Hill the Medical Examiner must be notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 529 Lieby Road USA 21623 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Sletus 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, While, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If hem 27 is marked other I 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Emmitt Leager Anna Dulin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Louise Leager 529 Lieby Road, Church Hill, Maryland 21623 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete Sudlersville Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6/3/2000 Sudlersville, MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

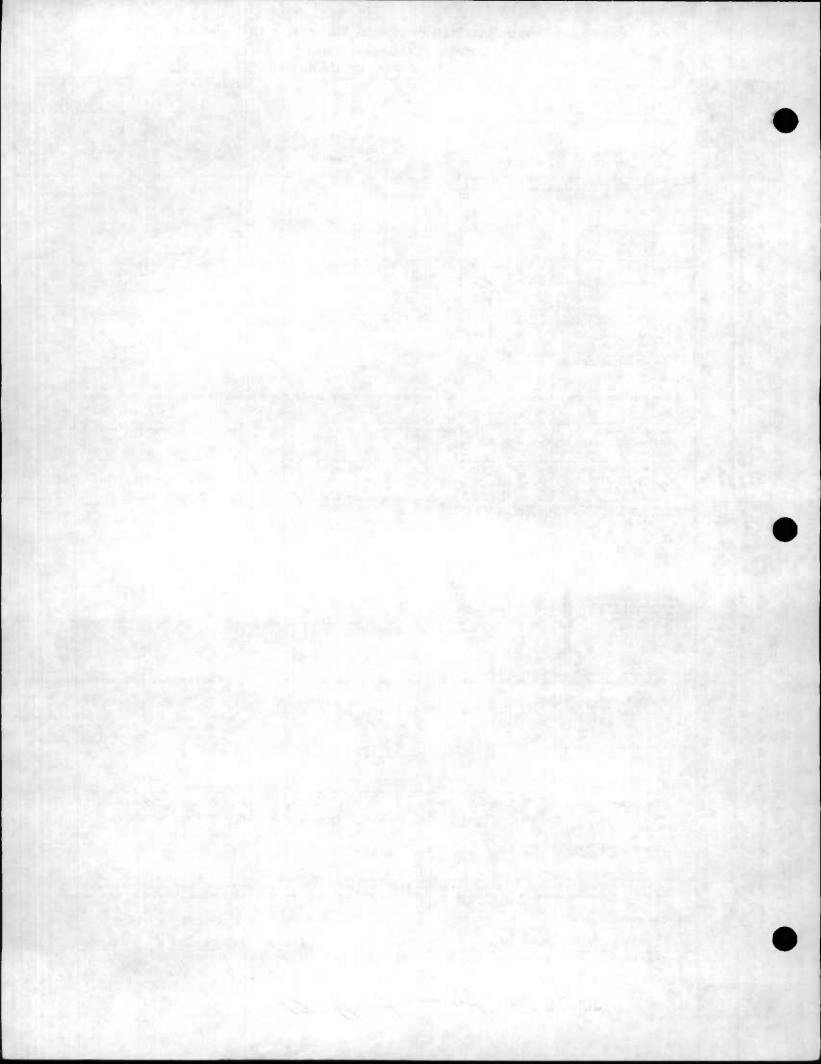
Approximate

Approximate Approximete Interval Between Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Hemorrhagic Examine Due to (or as a consequenca of) Examiner Hypertension physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of VItal Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 ☐ Unknown ASPIRIN Toxicity þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was an autopsy performed? Completed cartificate has 2 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Monpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Dete signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number M. D. Au 417 6435A-12434 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI tumpha Ationo 31. Date filed (Month, Pay, Year) 32. Registrar Signature State JUN 02 2000 ▶ Registrar

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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587 Kevins 11. Marital Status 1 Never Married 25 3 Widowed 4 Div	_	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:			Yes, specify Cub		erto Rican, et	:.)		k, White, Whi		
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19a. Informant's Name/Rei	letionship (7	ype, Print)		19b. Mailin	g Address (Stree					State, Zip	Code)	
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Laura L. Laubach June 6, 2000 6:00 a.m. 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 5434 Cannon Rd. Cambridge Dorchester 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) Months Days 1□ M 20 F 219-01-6066 94 Yrs. Nov. 30, 1905 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🗓 No Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5434 Cannon Rd. 21613 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Naver Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify. 3 ₩ Widowed 4 Divorced White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surname) Frank Willis Annie C. Glossner 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 5434 Cannon Rd., Cambridge, MD 21613 John J. Willis/Son 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cambridge Crematory 6-9-00 Cambridge, MD ire of Funeral Service Licenses 22. Name end Address of Fecility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 d the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximate Interval Between Onset end Death Immediata Cause (Final disease or condition resulting In death) Due to (dr as e consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 ING 3 Probably 4 Unknown 24b. Ware autopsy findings eveileble prior to completion of cause of death? 24a. Was an autopsy performed?

**Physician** /Medical **Examiner** 

ettending physician

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certificate has

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The law requires that the death

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

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Completed

Be

**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Ia markad other than "natural", or items 23a or 28a-1 show eny Injury or other traumatic event, the Medical Examiner must be northed at

Baltimore, Maryland 21215-0020

buriel-transit the 80 esn to deteched signed t

Examiner Physician/Medical by Completed To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, t Be 10 Medical Certification:

Division of Vital Records, P.O. Box 68760

						1 Yes 2 No 1 Yes 2 No	
25. Was case referexaminer?		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA	Othor	Death (Check only on	
27. Manner of Deat  1 ☑ Natural  2 ☐ Accident		28a. Data of Injury (Month, Dey Year)	28b. Time of Injury		Injury at Work?	home 5 Presidence 8 □Other (Specify)  28d. Describe how injury occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not b		noma, farm, street	, factory, of	ffice	281. Location (Street end Number or Rurel Route Number, City or Town, Stete)	
29a. Certifier (Check only one)	1 Certifying Ph 2 Medicat Exam	yatctan: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death or ation and/or inves	ccurred at t	he time, data and place my opinion, death occ	ice, and dua to the cause(s) and menner es stated.  scurred at the time, date and place, and due to the cause(s)	

29c. License number

29d. Date signed (Month, Dey, Year)

State Registrar 31. Date filed (Month, Day, JUN 0

29b. Signature and title of certifier

Aurora St., Cambridge, MD

108 8 7 8 10 miles

Division of Vital Records,

McFadden, Robert

altimore, Maryland 21215-0020

Box 68760

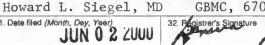
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State Registrar

31. Dete filed (Month, Dey, Yeer)
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30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)





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	Physici /Medic		CHARL	OTTE Q	. MAN	NING						Month MAY	Day 21	200		:15
	Examin		4a Facility Name	(If not institution	on, give s	treet and nu	m <i>ber)</i>			et Pos	4b. City, Town, or	Location of Dea	th 4c. Co	ounty of Dec	ath	
			7.0.110						L@EAS		EASTON			LBOT		
8	Funeral		5. Social Security 028-20-		6. Sex	M 200 F	-		last birthdey) Yrs.	Months Days		(Month, D			rthplace (Stet	
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)	€ 8 €	Director	10e. Street and No							10f. Zip Code			10g. Citize	n of What C	Country?	
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5-0020	72 hours after dec natural", or items ileal Examination	by Funeral	11. Marital Status 1 ☐ Never Mar 3 ☐ Widowed		rried	Armed For 1 Yes If Yes, Gir	Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No It Yes, Give Year or Dates:			was Decedent or if Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer Specify:	to Rican, etc.)		Black, Wh		-13
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	diffica	Bec	25. Was case refe	rred to medica	al _						26. Place of De	ath (Check only	one)			
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			30. Name and add	tress of person	no cor	npleted caus	se of de	eath (Item	1 23a) (Type,							77.14
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	Sta	_	31. Date filed (Mo.	nth, Day, Year	) -	32. F	egistra	r's Signa		D. D.	parks					
	Registra	ar		MA	12	2 2000	1			, ,						

# mccollum, Goy E.

1. Decedent's Name (First, Middle, Last)

Month Year **Physician** 0 Gav E. McCollum 2000 /Medical non of Death 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Loca 4c. County of Deeth Examiner Arunde 16 Social Security Number Hospital 301 Harpital Drive len Durnie If Under 24 Hrs. 8. Data of Birth Hours | Min. (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) 72 Yrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 □ M 2XIX 578 42 4041 Director 11/12/1927 Germany Usual Residence of Decedent with the Marylend 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXNo MD Anne Arundel Severna Park Director or 28a-f 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 43 West McKinsey Road #325 21146 USA or Nerna 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Maritat Status Was Decedent Ever in U,S. Armed Forces? Black, White, etc. filed within 72 hours after 1 Nevar Merried 2 Merried 1 ☐ Yes 2 ☐ No Maryland 21215-0020 1 Yes 2√2 No Specify: Specify: White Completed by 3 ₩ Widowed 4 Divorced Year or Dates 'natural', 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Insurance Company other 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) h and Mental F Pages 1 and 2 should be Gerhart Husserl Else Tammann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth ar Important: if itsm 27 is any injury or other trau Walter Childs/personal rep. 145 Main Street, Annapolis MD 21401 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlat 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 6/7/00 Alexandria VA 21. Signature of Funaral Service License 22. Nama and Address of Facility Mela Advent Funeral & Cremation Services Annapolis MD 21401 23a. Part1. Enter the disease, or complications that caused the deatt bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Intervat Batween Onset and Death **Physician** Immediata Causa (Finat disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner 201 The lew requires that the death certificete be executed Sequentially list conditions, if any, taading to immediata cause. Enter Underlying Cause (Disease or Injury as e consequence of): P.O. Box 68760 X PGS that initiated evants resulting in death) Last Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3D Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of Vitai Records, Be Completed by 24b. Wara autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 2 ☐ No certificate Cerdeno Usa 601 Attending Physician: funeral director, 25. Was case raferred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpalient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 (DNature) 5 Pending investigation within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 8 Hospital edical 29a. Cartifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the P 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 102 Glen Bringe BADR crayy 1100 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State Registrar JUN 0 7 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2 Date of Death

DHMH 16 Rev 6/95



# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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			Certificate of Death		Reg. No.	0 12002
	Physicia	_	1. Decedent's Neme (First, Middle, Last)	2. Date of De Month		3. Tima of Death
	/Medica	al -	HOWARD MAKELL 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or	JUNE		0446
	Examine	er			4c. County o	f Deeth
	4	4	ANNE ARUNDEL MEDICAL CENTER ANNAPOLI  5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year   If Under 24 Hrs			ARUNDEL
	Funeral Director		216-3201300 TO M 2 F 92 Yrs. Months Deys Hours Min	. (Month, D		9. Birthpleca (State or Foreign Country)  MARYLAND
	death with the Maryland rms 23e or 28e-f show it must be notified at		10a. Stete 10b. County 10c. City. Town or Location			10d. Inside City Limits 1X Yes 2 □ No
	with the Maryland a or 28e-f show	Director	maryland ANNE ARUNDEL GALESVILLE  10e. Street and Number 10f. Zip Code		10g. Citizen of Wi	
	th with		928 W. BENNING ROAD 20765		USA	
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-	f Haalth tem 27	-		Dete Dete		Oity or Town, State
Baitimore	Sec H		1 ☑ Buriet 2 ☐ Cremetion 3 ☐ Removet from State 4 ☐ Donation 5 ☐ Other (Specify)  EBENEZER AME CHURCH	6/6/00		ILLE, MD.
Bai	pemit. Pag Department Important: any Injury ence.		21. Signatura of Funarel Service Licensee  Hong J. Leese M00482  WM. REESE & SON	S MORT	UARY, P	.A.
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Records,	w requires that been signed b should be date	Completed	Jerphot Moberler disease, Type III	24e. Wa	s en autopsy ormed?	24b. Were eutopsy findings avaitable prior to complation of causa of death?
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of Vital	delan: The certificata rector, pag		25. Was case referred to medical 26. Place of De	eth (Check only	one)	
<b>&gt;</b>	5 00	0	exeminer?  1 Yes 20 No Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Res	idence 6 Othe	r (Specify)
	ding Ph. After th funeral		27. Magner of Death 1 ☑ Naturet 5 ☐ Panding 28e. Dete of Injury (Month, Dey Year) 28b. Time of injury 28c. Injury et Work?	28d. Describe	how injury occurre	ıd
Sio	Attending r death. ector: Afte by the fune	cati	2 Accident investigation M 1 Yas 2 No		(0)	8 18 11
Division	or Attending Phater death. Director: After this in by the funeral	Certification:	determined  28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)		(Street end Numbe own, Stete)	or or Rurel Route Number,
			29e. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place	e, end due to the	ceuse(s) end mar	ner es stated.
	the Ho hin 24 the Fu npieter	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred and manner stated.	urred et the time		
	To the To the Compie	Σ	29b. Signature and title of certifier 29c. License number	2	29d, Date signed	(Month, Dey, Year)
			, cm 122ma 6 , 00642	3	0-1-	00
			30 Name and address of person with completed cause of death (Repressor (Type, Print) 33 A Fo	S bos	2.12	n. Mogrator
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signatura			

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be flied within 72 hours after death with the Manyland Department of Health and Mental Hygeno. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

altimore, Maryland 21215-0020

Physician /Medical Examiner

The law requires that the death certificate be executed and the burial-tran P.O. Box 68760. physician USe as ed by the g signed b Division of Vital Records, peeu page 2 s certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica director. funeral To the Hospital or Attervition 24 hours after der To the Funeral Directo completely filled in by the

Certificate of Death 1. Decedent's Nama (First Middle Last) 2. Data of Death 3. Tima of Deeth Month Yaa 18.30 Bernice Louise Meredith - 2000 6 4a. Fecility Nama (If not institution, give street and number) Emergency Room 4b. City, Town, or Location of Death 4c. County of Death Dorchester General Hospital Cambridge Dorchester If Undar 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Dey, Yaar) March 7, 1921 Maryland 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Steta or Foreign Country) 1□M 2XF Months Days Hours Yrs. 212-16-1489 Usual Rasidance of Dacedent 10a. Steta 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Director Maryland Talbot Trappe 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1957 Ocean Gateway 21673 U.S.A. Funeral 12. Was Dacedant Evar in U.S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indian Bleck, Whita, atc. 1 ☐ Yas 2 🗓 No If Yas, Giva 1 ☐ Nevar Married 2 ☐ KMarried 1 ☐ Yas 2X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Yaar or Datas: Completed 16e. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 8 Shellfish Crab picker 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnema) Be George Murphy Olive Meredith ပ 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, State, Zip Code) Spouse Sr Amos Tawes Meredith, 1957 Ocean Gateway, Trappe, MD 21673 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Bunal 2 □ Cramation 3 □ Removel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Dorchester Mem. Pk. 6-4-00 Cambridge, MD 21. Signature of Funeral Service Lin 22. Nama and Address of Fecility
Curran-Bromwell Funeral Home, P.A. 23a. Pentt. Entar tha disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death ARTERIOSCLEROSTE CARDIOUASCULAR Immediata Causa (Final diseesa or condition rasulting in death) Examiner Sequantially list conditions, if any, laading to Immadiata causa. Entar Underlying Causa (Disaasa or Injury that Initiated events rasulting in deeth) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown by DIABETES MELLITES 24b. Wara autopsy findings aveilable prior to completion of cause of daath? Completed 24a. Was an autopsy performed? 1 ☐ Yas 2 No 1 □ Yas 2 □ No 25. Wes casa rafarred to medical examinar?
1 ☐ Yas 2 ☐ No Be 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Data of Injury (Month, Day Yaar) 28c. Injury at Work? 27. Mannar of Deeth 28b. Time of 28d. Dascribe how Injury occurred Certification: 1 Naturel
2 Accident 5 Panding 1 Yas 2 No Invastigation 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, ferm, straat, fectory, office building, atc. (Spacify) 28f. Location (Streat and Numbar or Rurel Routa Number, City or Town, Stata) 4 Homicida 29e. Certifiar Certifying Physician: To tha bast of my knowledga, daath occurred at the time, dete end piece, end due to the ceuse(s) end mannar as steted. Medical (Check only one) 2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, death occurred at the time, date and plece, end due to the ceuse(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licanse numbar 29d. Date signed (Month, Dey, Year) 00 30. Nama and address of person who complated cause of death (Item 23e) (Type, Print)

105 Aurora St., Cambridge, MD 21613

State Registrar Mahmood Shariff,

31. Data filed (Month, Day, Year)

JUN 0 6 2000

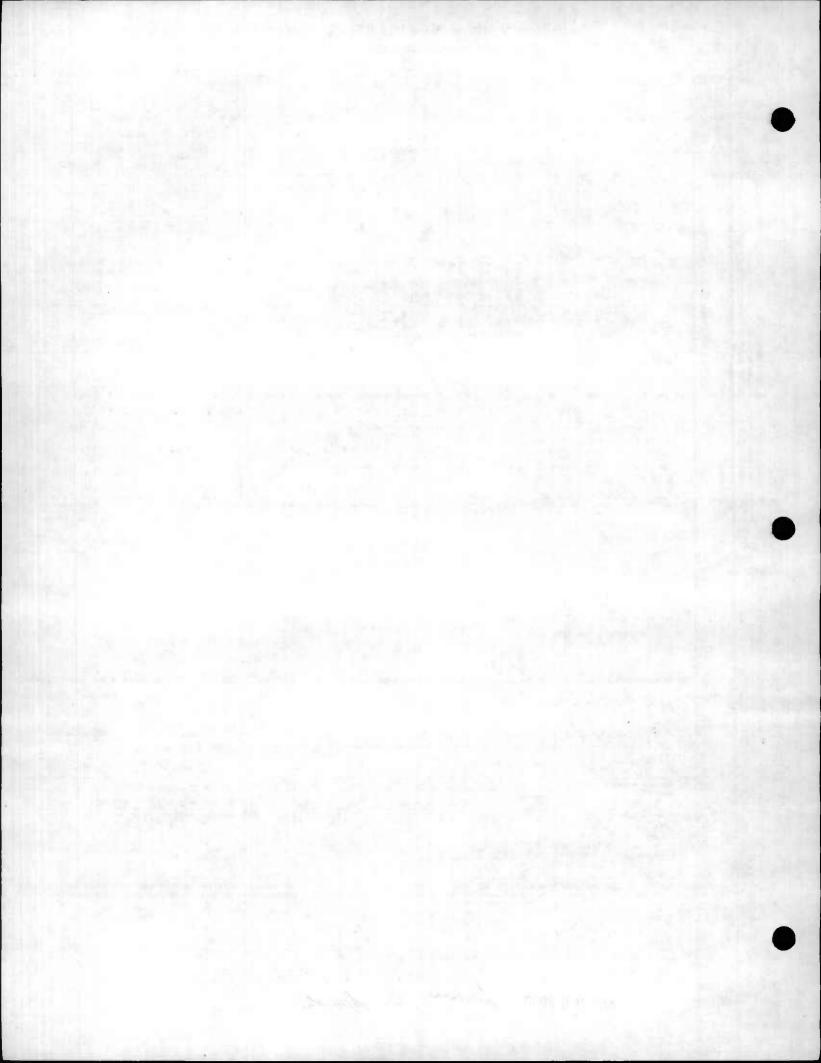
M.D.

32. Ragistrar's Signatura



	Decedent's Neme (First, Middle, Last)		2. Date of Death		3. Time of Death
Physician	ASHER CARLTON MOORE		Month May 2	23, 2000 ear	9:30 AM
Medical/ Examiner	4e Facility Neme (If not institution, give street end number)	4b. City, Town, or L	-	4c. County of Dee	th
LAGIIIIICI	Salisbury Center; Genesis ElderCare	Salisbur	y, Md.	Wicomico	
uneral rector	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Y			Year) 9. Bir	thplace (State or Foreig ountry) ARYLAND
B w	10a. Stete 10b. County 10c. City, Town or Location			~	10d. Inside City Limit
notified	DELAWARE SUSSEX BETHANY BEACH			2	1 X Yes 2 □ N
be notified Director	10e. Street and Number 10f. Zip Co	de	109	g. Citizen of Whet Co	ountry?
		930		USA	
Funeral	11. Meritel Status 12. Wes Decedent Ever in U.S. 13. Was Decedent	of Hispanic Origin? (Sp	ecify Yes or No-	14. Raca - Ame	
by	Agreed Forces?  1 Never Merried 2 Merried   1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Cuban, Mexican, Puèrto No Specify:	moan, etc./	Bleck, White	WHITE
pete	15. Decedent's Education 16a. Decedent's Usuel O (Specify only highest grade completed) (Give kind of work d	ccupation lone during most of work	ring 16	6b. Kind of Business	Andustry
Completed	Elamentery/Secondary (0-12) College (1-4or 5+)  2 VICE PRESID	etired)		BANKING	
Bec	17. Fathar's Neme (First, Middle, Lest)		e (First, Middle, Me	eiden Sumema)	
ToB	JOSEPH L. MOORE	NEVA	T	RUITT	
-	19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (SI	treet and Number or Rur	ral Route Number, (	City or Town, Stete,	Zip Code)
	DOROTHY H. MOORE/WIFE P.O. BOX 10	49. BETHAN	BEACH.	DELAWARE	19930
	20e. Method of Disposition  1 🛱 Buriel 2 □ Cremetion 3 □ Removel from State  20b. Place of Disposition (Name of cematery, cremetory or other	of r plece)	Dete 20	Oc. Location - City or	Town, State
	4 Donetion 5 Other (Specify) BISHOPVILLE CE	METERY 5	/26/00 BI	SHOPVILLE	, MARYLAND
my inju	21. Signature of Typeral Service Licensee 22. Name and A	ddress of Facility			
8 8	HASTINGS	FUNERAL HO	ME, SELBYV	VILLE, DEL	AWARE 1997
	23a. Pert . Enter the disease, or complications that can be differed deeth. Do not enter the mode of shock, or heart failure. List only one cause on each line.	dying, such as cardiac	or respiratory arras	st,	Approximete Interval Between
as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as e consequence of):				
	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.	23b. Did tob	acco usa contribut	to the cause of deat
by Phys	1		1/2 Yes	8 2□ No 3□P	robably 4 Unkno
pleted	COSD Pense pode	e	24a. Was an performe		Were eutopsy findings available prior to completion of cause of death?
E	Onosonyo onocer		1□ Yes	20/No	1 Yes 2 No
O	28. Wes case referred to medical	26 Blanc of Duct	th (Check only one)		10.100
0	exeminer? 1	Other		ice 6 Other (Spe	naif al
Certification: To Be Completed by Physician/Medical	27. Manner of Death 1. Neturel 5 Pending 28e. Dete of Injury (Month, Dey Year) Injury 28c.	Injury st Work?	28d. Describe how		спу)
ertifica	2 Accident Investigation 3 Suicida 6 Could not be determined 28a. Place of Injury - At home, ferm, street, fectory, of building, etc. (Specify)		281, Location (Stre City or Town,	eet end Number or R Stete)	lurel Route Number,
ately filled	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the Check only one)	ne time, date end placa, my opinion, deeth occur	end due to the ceu red et the time, dat	use(s) and manner e te end pieca, and du	s stated. e to the cause(s)
Me	A with the state.	cense number	290	d. Data signed (Mon	th, Day, Year)
	1114	199.7	200	5/22/	CXO
	0000	21012		-1 4	
	30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)			204	
	M ATKINS MD 1104 HEALTHWAY DI	R., SALISBUR	Y, MD 218	304	
State	31. Date filed (Month, Dey, Year)  MAY 3 0 2000  32. Regisfer's Signeture				
Registrar	MAV & IT THEIR	120 11.			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death



## Piease Type or Print in Black indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Year Month **Physician** LILLIAN MALTILDA MOHN 2000 110. 20 Walu /Medical 4a Facility Name (II not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO H Under 24 Hrs.
Hours Min.

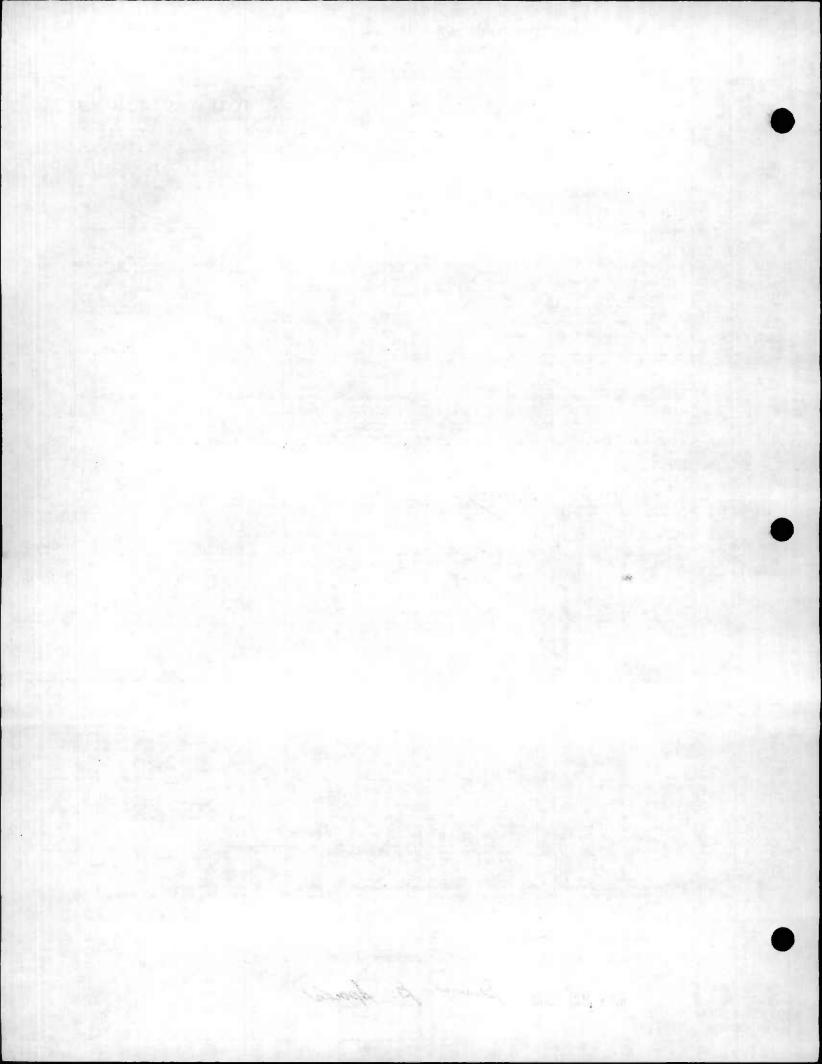
8. Date of Birth (Month, Day, Year)
APRIL 6, 1914 PENNSYLVANIA If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days 1□ M 2∏ F 180-10-5396 Yrs. Director 86 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Mexical Examiner must be notified at DDE. 1 ☐ Yes 2 No Director SALISBURY MARYLAND WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 1514 RIVERSIDE DR. APT. 221C U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 □ Never Merried 2 □ Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 11 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be WEINER WILLIAM W. SIGMUND LILLIAN Μ. 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA PASTORFIELD - DAUGHTER 118 JOHNSON DR. SALISBURY, MD 21804 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stete SPRINGHILL MEMORY GARDENS 5/23/00 HEBRON, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility 705 E. MAIN ST. 21. Signeture of Funeral Service Licensee BOUNDS FUNERAL HOME, INC. SALISBURY, MD. 21804 23a. Party: Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on the line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical SEPSIS Ly AC Examiner Due to (or as a consequence of): Physician/Medical Examiner NEVMONIA DAYS The law requires that the death certificate be executed for use as the burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): P.O. Box 68760, Due to (or es e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the causs of death? 1 Yes 2 Probably 4 Unknown HYPONATREMIA Records, ð page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en eutopsy certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpetient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hespital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No investigetion 2 Accident 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) and menner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 al M.D. 029168 5/20/00 st 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) ROBERT ALLEN 560 RIVERSIDE DR. A204 SALISBURY, MD 21804

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year) MAY 23 2000

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** June June 2000 9:27P.M. Neal Francis /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center LaPlata Charles M Under 1 Year | M Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign **Funeral** Days 10XM 20 F 7,1945 Maryland Yes 54 Director 217-44-9917 November Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location t0d. Inside City Limits TX Yes 2 No notifie Director Hall Maryland Charlotte Charles 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA "natural", or flama 23a 20637 14178 Oaks Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 22 No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver Silver Hill Gravel 12 parmit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 is marked other
any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Woodland Elsie Charles H. Neal Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14178 Oaks Rd. Charlotte Hall, Maryland 2063 Alice Neal-20a. Method of Disposition

1 Burial 2 Cremetion 3 Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6/12/00Bryantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) \$T. Marys Cemetery 20608 21. Signature of Funeral Service License 22. Name and Address of Fecility W00191 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part I. Enter the decomp, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fall and List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a gi Examiner physician and s the burlal-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or as a consequence of): 66 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detact 1 Yes 2 No 3 Probably 4 Unknown Records. by Completed 24e. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? ate has page 2: ... crospital or Attending Physician: Th. thin 24 hours after death, the Funeral Director; After this olderly filled in the 1 Yes 2 No 1 Yes 2 No certificate Division of Vital å 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1□ Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28d. Describe how injury occurred 2ffa. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Localion (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 2 Medical Exa To the I within 2 To the I complet 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D-22574 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12070 Old Line Center, Suite 202 Robert T. Pace, Waldorf, Maryland 20602 M.D

DHMH 16 Ray 6/95

State

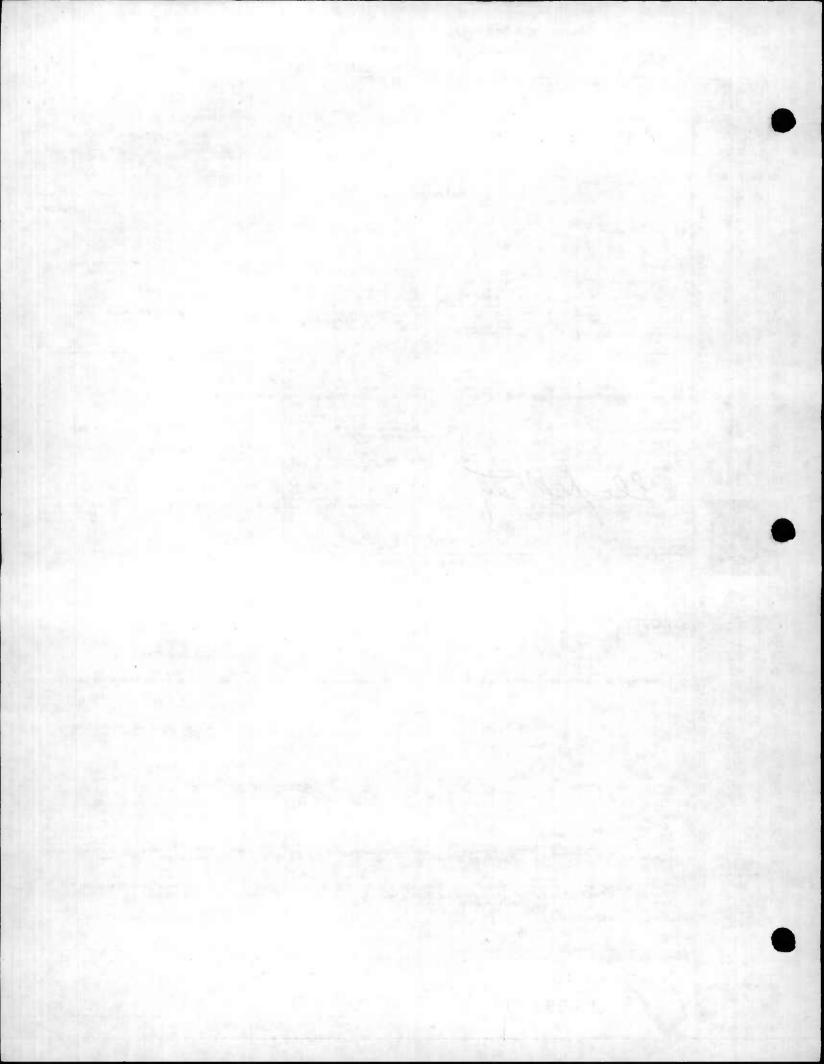
Registrar

31. Dete filed (Month, Day, Year)

32. Registrar's Signature

Dener

JUN 0 9 2000 >



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month Year Physician 1935 William Nash, Sr. 13 2000 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner The Kent and Queen Anne's Hospital, Inc. Chestertown 5. Social Security Number 6. Sex 1DXM 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Yrs 073-09-0397 Director August 29, 1918 New York **Usual Residence of Decedent** permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show eny injury or other treumatic event, ma Heddel Estimat Institut be notified at each. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits VO Yes 2 □ No Funeral Director Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Morgnec Road 21620 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 DXYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ONO Specify: Specify: White à 3\OWidowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Industrial Engineer US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Henry Nash Lillian Mulligan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Eleanor Laws 411 Campus Avenue, Chestertown, Maryland 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 4 □ Donation 5 □ Other (Specify) 5/20/2000 Brentwood, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical cessation of respirations Examiner Due to (or as a consequence of): Physician/Medical Examiner Meta static The law requires that the death certificate be executed anding physician and use as the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Due to (or as a consequence of). pege 2 should be deteched to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 20 No 2 NO certificate 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 1 @Naturat 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

he Hoopital or Attending Prystuters. In 24 hours effer deeth.
The Funces Director: After this certificate spietely filled in by the funeral director, pr completely within 2

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

20055127

5-13-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

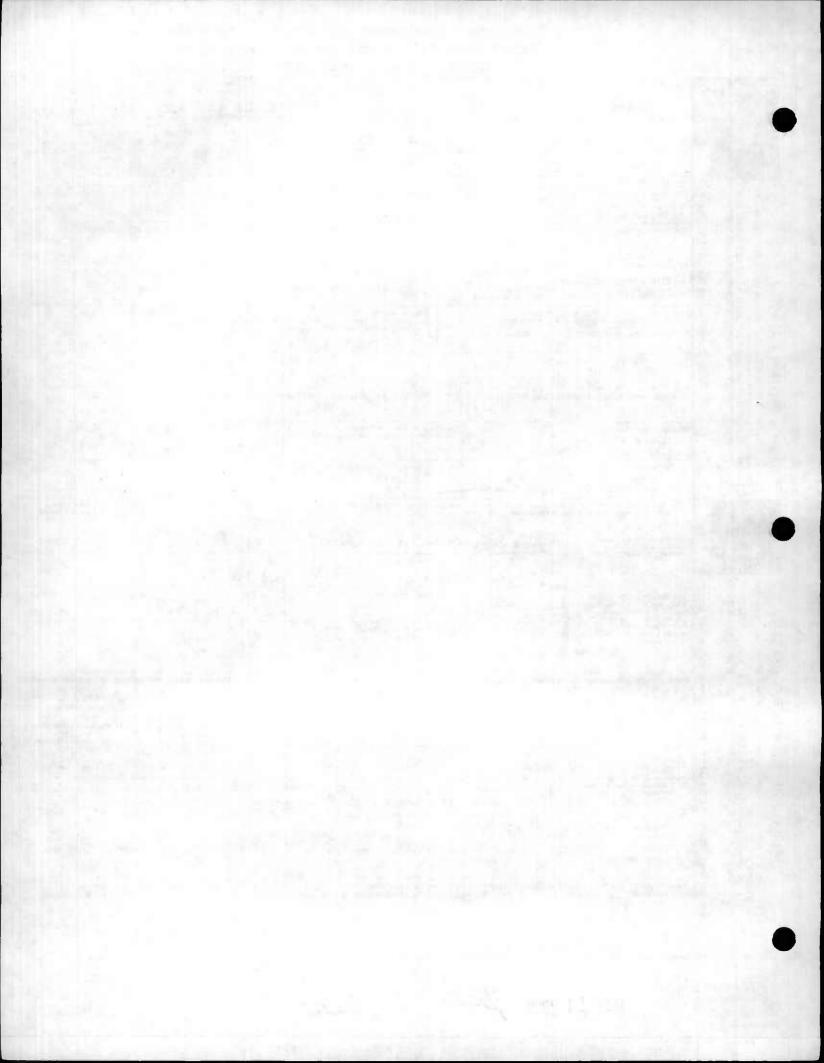
516 Washington Avenue, Chestertown, Maryland 21620

State Registrar

(Check only

29b. Signature

31. Date filed (Month, Day, Year) MAY 15 2000 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month 24 24 Dorothy 2000 May Newcomer 0045 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner The Kent and Queen Anne's Hospital, Inc. Chestertown Kent 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dev. Year)

June 28, 1925 Columbia, PA Birthplace (State or Foreign Country) **Funeral** 1 M 2XX Days Yrs. Director 171-20-9674 **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mingortant of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or here 23s or 28e-f. any injury or other treumatic event, the Medical Examinar must be notified any injury or other treumatic event, the Medical Examinar must be notified. Directo Maryland Kent Rock Hall 10e. Street and Number 10f. Zio Code 10g. Citizen of Whet Country? 5795 Chesapeake Villa 21661 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: White Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be William H. Carnahan, Sr. Agnes Wickenheiser 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Deb Feltenberger 130 North 14th Street, Columbia, PA 17512 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Perovel from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Trinity Catholic Cem. 5/27/2000 Columbia, PA 21. Signatury of Juneral Service Licensee 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hearthailure. List only one cause on each line. Approximete Intervet Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical He tostatic @ Breast caninamente Bone Examiner Due to (or as a consequence of): Broth MHS tectoring physicien end s the budel-transit certificate be executed Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Right Breast carcinoun Physician/Medical Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown TO BACCO ABUSE by 24b. Were eutopsy findings eveilable prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? 1 Tes 2 1 No 1 ☐ Yes 2 ☐ No this certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours efter deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director, 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describs how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbar 29d. Date signed (Month, Day, Year) 123889

State Registrar

DHMH 16 Rev 6/95

V. sparks

948 WAShington Ave, CHEStestown Md 21620

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

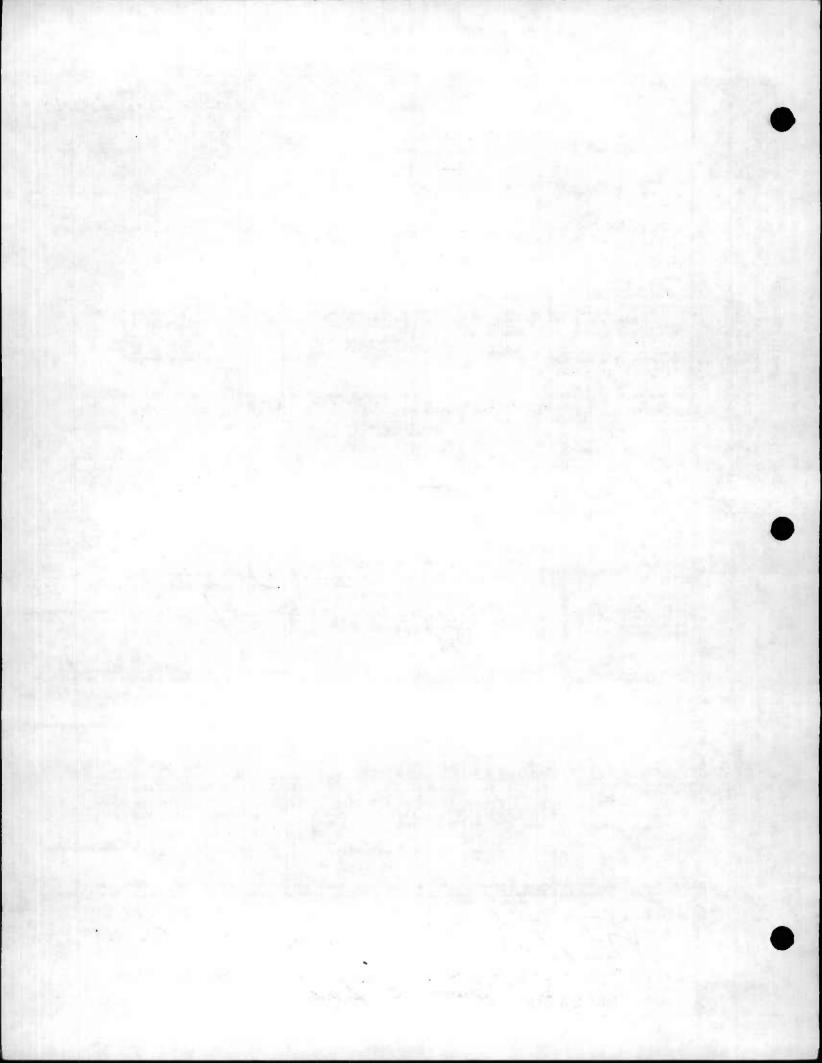
32. Registrar's Signature

Volanc. ARRABAL TR M.D.

MAY 2 5 2000

31. Date filed (Month, Day, Year)

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Physician /Medical	1. Decedent's Name (F GENEVIEVI	Ξ	W.	NICH	HOLS	31			2. Date of De Month	18, 20 c	The state of the s	RI40
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ctor	239-32-807 Usual Residence of De		□ M 2FXF	85	Yrs.	Months	Days	Hours Min.	NOV.10	, 1914		CAROLIN
ctor		b. County SUSSEX			y, Town or Lo [LTON	cation						fnsida City Limit 1∭ Yas 2□ N
Funeral Director	10e. Street and Number 417 FEDERA					10f. Zip	code 9968			10g. Citizan of USA	What Country	
P	11. Marital Status  1 Never Married  3 Widowed 4		12. Was Decedent Armed Forces? 1 Yes 200 If Yas, Giva Year or Datas:			Was Deced f Yas, spec I□ Yas	7.5	spanic Origin? (S n, Mexican, Puar Specify:	pecify Yas or No to Rican, atc.)	o- 14. Ra Bla Specia	ce - Amarican ick, Whita, atc. by: WH	
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To Be Co	17. Father's Nama (Fire ROBERT WA				BOOK	(EEPE)	K	18. Mother's Ne JESSIE	me (First, Middle ALLEN	MEAT PR		NG
	19a. Informant's Name CHARLOTTE	/Relationship (7) ALLEN N	ype, Print) IICHOLS—DA	UGHT	19b. Mailin R 417	Addrass FEDE	(Street a	and Number or R ST., MIL	TON, DE	per, City or Town	, Stata, Zip Co	da)
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76	cause. Enter Underlyic Cause (Disease or inju- that initiated events resulting in death) Last	ry T	d	1	as a consequ	Lence of):	1	scjen	12/	n Jan	chin	~~~
Physician/Medic	Part II. Other significan	nt conditions co	ontributing to death b	out not resu	ulting in the ur	nderlying c	ausa giv	an in Part I.		tobacco use co		e cause of death
Completed by									24e. Was	s an autopsy ormed?	evaila	autopsy findings bla prior to lation of causa lth?
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6	axaminer? 1 Yas 2 No.  27. Manner of Death Natural 5	Pending	Hospital: 12 Impation 128a. Data of Inju		ER/Outpatien 28b. Tima of Injury		OA Other	er: 4 🗆 Nursing I	toma 5□Ras			
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Medical Certifi	29a. Certifier (Check only 2)	Certifying Phy Medical Exami	nician: To the best	f axaminat	wledge, death ion and/or inv	occurred oraștigation,	at tha tim	ea, data and place pinion, daath occ	e, and due to the urred at the time,	causa(s) and m	annar as state , and due to the	d. a causa(s)
-	29b. Signature and title	at cogillor )	TH		,		. License	number 44/		29d. Data sign	od (Month, Day	
	30. Namerana acceptage	of person while o	ompleted causa of d	leath (Item	23a) (Type,			aliko		. = .		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey Month **Physician** 9= ORGE OSTEN DANA WILLIAM 9:35 AM 06-03-2000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FALLSTON GENERAL HOSPITAL FALLSTON HARFOND 7. Age (In yrs. last birthday) If Under 1 Year Months Days Hours Min. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 10 M 2 F Director Maryland 243-40-9228 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 20XNo Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 8 108 C Seevue Court 21014 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW T Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 72 hours after 1 Never Married 2K Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry of be filed within 7 intal Hygiene. ed other than "n event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Steel Manufacturing Mechanical Engineer parmit. Pages 1 and 2 should be the Department of Health and Mental My Important: If 1tem 27 is marked othe any Injury or other traumatic event page. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Charles Francis Ostendarp Irene Bessie Woollen 19a. Informant's Name/Relationship (Type, Print) 198. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris L. Ostendarp-wife 108 C Seevue Court, Bel Air, Maryland 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 ☐ Cremation 3 DRee Hilltop Service Corp. 6/5/00 Towson, Maryland 21. Sig ne of Furneral 22. Name and Address of Fecility McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, Maryland 21014 art1. Enter the dis each line. Approximete Intarval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ASCUD Examiner Due to (or as e consequence of): Physician/Medical Examiner attending physicien and for use as the buriel-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760, Due to (or as e consequence of): been signed by the a should be detached Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ Completed 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? 1 Yes 2 No 1 Yes 200No certificate Division of Vital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ EFVOutpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendin within 24 hours stier death. To the Funerel Director: Af 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) OCME OME JUN 3- 0 2000 30. Name and address of person who completed cause of death (Item 23s) (Type, Print) 2041 GPRASIN M.O 728 BELAIR BELAIR MD 21014 410 879-6564 M 31. Date filed (MUN 0 5 2000

Registrar **DHMH 16 Rev 6/95** 

State

JUN 0 5 2000 Some I fract

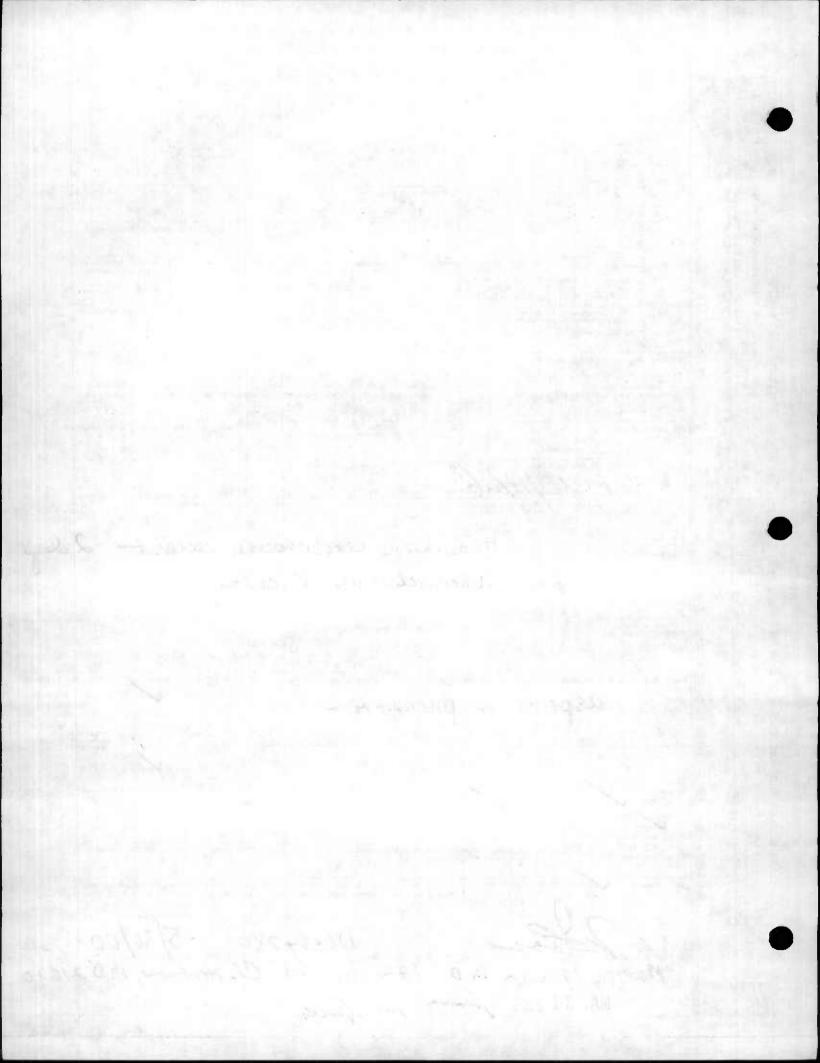
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Physician ROBERT 29 TARBELL OLIVER 2000 0518 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT QUEEN ANNES HOSPITAL CHESTERTOWN KENT If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 7, 1909 If Under 1 Year 9. Birthplace (State or Foreign Country) Sweet Home, OR 5. Social Security Number 6. Sex 1 XM 2 F 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours 90 097-22-7482 Yrs. Director Usuel Residenca of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 28a-f ahow treumstic event, the Medical Examiner must be notified at XXYes 2 No Directo Maryland Chestertown Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Нета 23а 204 Heron Point 21620 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ONo If Yes, Give Yeer or Detes: 14. Race - American Indian, Bleck, White, etc. 11. Meritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after all Hygiene. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12 College (1-4or 5+) Education/Literature Professor & Writer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked ofth any Injury or other traumatic event ADE. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Harry O. Oliver Iris Tarbell 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pauline Oliver 204 Heron Point, Chestertown, Maryland 21620 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 【ACremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Cremation Center, LLC 5/29/2000 Stevensville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 net caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, on each line. 23e. Part1. Enter the diseese, or conshock, or heert failure. List on Physician /Medical Immediate Cause (Finel disease or condition resulting In deeth) Cerebro vascular accident emorrhagic Examiner Due to (or es e consequence of) Physician/Medical Examiner Therosclerotic sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of): Box 68760. attanding physician for use as the buria that initiated events Due to (or es e consequence of) resulting in death) Lest P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown be det pheumorio Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an eutopsy performed? 1 Yes 200 No 1 ☐ Yes 2 ☐ No cartificata Division of Vital Hospital or Attending Physician: 25. Wes case referred to medical axeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer 5 Pending investigation 1 DNeturel death. 1 Yes 2 No 2 Accident 24 hours after deat Funeral Director: 3 Sulcide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. Medical 29e. Certifier completaly miner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted. within 2 To the To the 29b. Signature and title of 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of pers no completed cause of death (Item 23a) (Type, Print) Chestertown Marisa mp. Cia 32. Registrar's Signeture 31. Dete filed (Month, Day, Year) State **MAY 31** 

**DHMH 16 Rev 6/95** 

Registrar

2000



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Deeth Day Month SARAH ELSIE THOMPSON PROCTOR 6:03P.M. June 2000 6 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Civista Medical Center LaPlata Charles 8. Dafa of Birth (Month, Dey, Year) MAY 26, 1902 5. Social Sacurity Number If Under 1 Yaar | If Under 24 Hrs. 6. Sex Birthplace (Stata or Foreign Country) MARYLAND 7. Aga (In yrs. last birthday) 10 M 2 F Days 98 Yrs 213-74-5331 Usual Rasidance of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND CHARLES **PISGAH** 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 20640 UNITED STATES 5400 STUCKEY ROAD 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 ☑ Widowed 4 ☐ Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 3RD. GRADE HOMEMAKER PRIVATE 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) ELIZABETH SWANN THOMPSON ALOYSIUS THOMPSON 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 20646 GEORGETTE KEYS / GRANDDAUGHTER 132 KALMIA COURT, LA PLATA, MARYLAND 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1K Burial 2 □ Cramation 3 □ Removal from Stata 4 □ Donation 5 □ Other (Specify) CATHERINE'S CEMETERY 6/10/00 MC CONCHIE, MARYLAND 21 Southura of Funéral Service 22. Name and Addrass of Fecility THORNTON FUNERAL HOME, P.A. THORNTON JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feiture. List only one ceuse on each line. Approximata Interval Between Onset and Death Immediata Causa (Final disaesa or condition resulting in death) ,5 hrs Sequentially list conditions, if any, taading to immadiata cause. Enter Underlying Cause (Diseasa or Injury that initiated avants resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 20 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yas 1 ☐ Yas 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

Completed

Be

**Funeral** 

Director

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72 hours after

filed within

permit. Pages 1 and 2 abouid be file Department of Meeth and Mental Hys important; if fem 27 is merited other any injury or other traumers observed.

21215-0020

Saltimore, Maryland

Examine physician and the burial-transit Physician/Medical be det à Completed Be Certification: To

The law requires that the death certificate be executed

Box 68760.

P.O. |

Records,

Vital

Division of

o Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica

within 2 To the \$

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pelli filled

Medical

25. Was case referred to medical 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 5 Pending invastigation

26. Place of Death (Check only one)

Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify)

28c. Injury at Work? 28d. Describe how Injury occurred

1 Yas 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one)

D-08370

29c. License number

29d. Date signed (Month, Day, Year)

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Paul E. Pritchett, M. D

6 Could not be datarmined

118 LaGrange Aveune P.O. Box 1317, LaPlata, Maryland 20646

31. Dete filed (Month, Day, Year) JUN 0 9 2000

1 Naturel

2 Accident

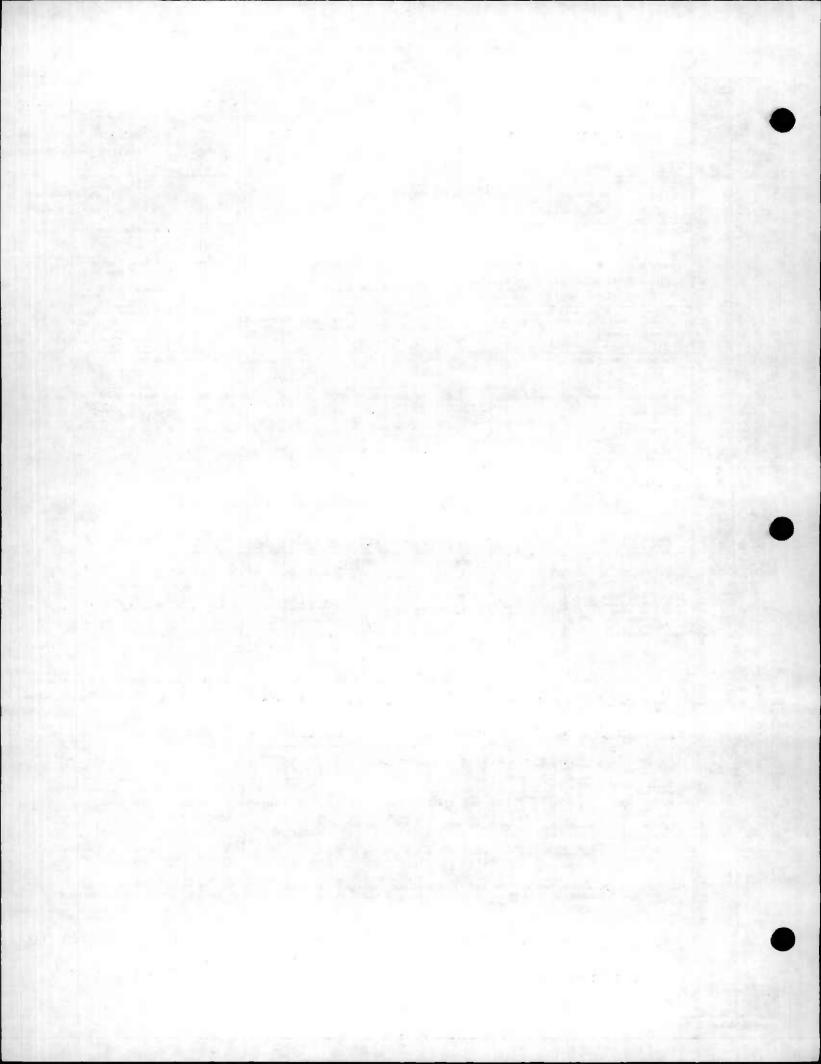
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29a. Cartifier

4 Homicide

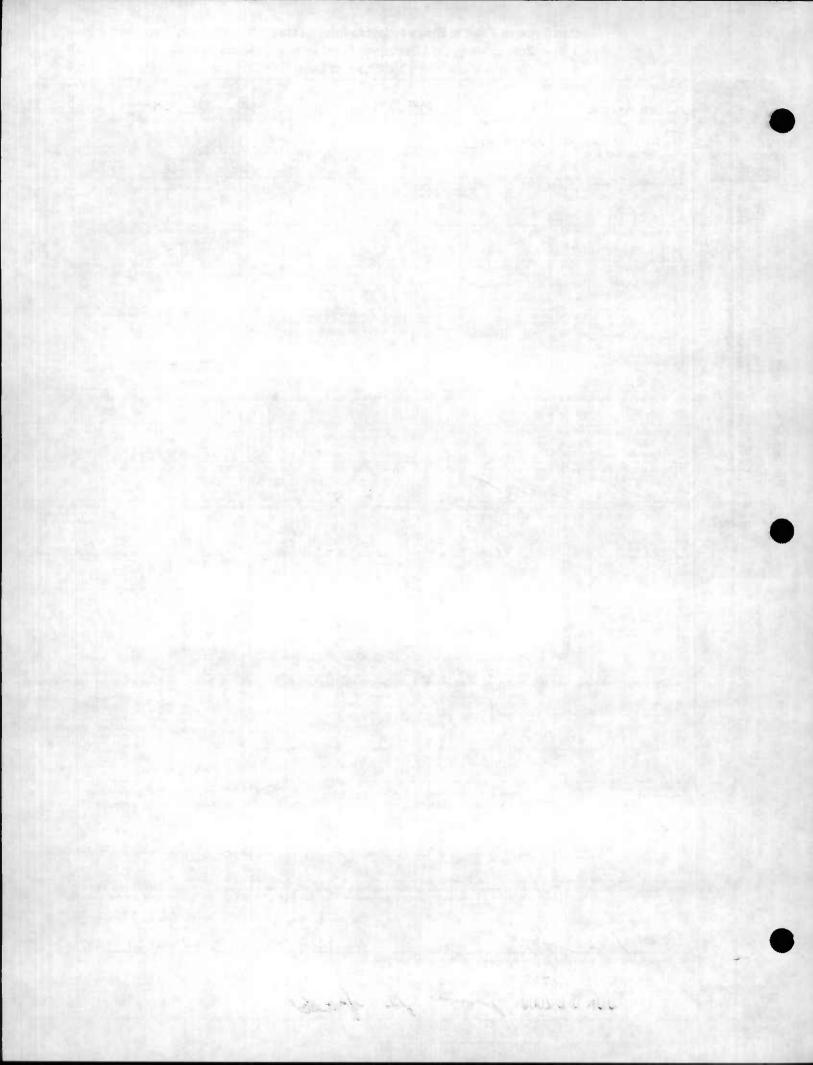
32. Registrar's Signeture

State Registrar



State of Maryland / Department of Health and Mental Hygiene 00 19380

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_	Decedent's Name (First, Middle, La	ist)			4.17				2. Data of De Month	ath Day	Yaar	3. Time of	Death
sician edical	Candace	M.		Preve	ette				May 3			00:	53
	Facility Name (If not Institution, given	e street end num	ber)				b. City, To	wn, or Lo	cation of beath				
	Johns Hopkins	Hospita	2/				Bult:	more	City	N/A			
	Social Security Number 6. 5	Sex 7	. Age (In yrs.	last birthdey)		ar 1 Year	If Under	24 Hrs.	8. Date of Birt		9. Birthp	lace (Stete o	r Foreign
	16-15-8604	1□M 2以F	15	Yrs.	Months	Days	Hours	Min.	June 1	y, Year) 9, 1984	Ken	tucky	
-	ual Residence of Decedent												
10a	a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside Ci	
à M	laryland Harford	d	Be	el Air								1 🗆 Yes	2 No
- ×	e. Streel and Number				10f. Z	ip Code				10g. Citizen of	What Coun	itry?	
9 1	541 Bentley Circ	nlo			1	1015				U.S.A.			
Funeral 11.	Marital Status	12. Was Deced	dent Evar in U,	S. 13. V			ispenic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		ce - Americ		
	1 Never Married 2 Married	Armed For	2 X No					i, Puerto	Rican, etc.)	Bia	ck, White,	etc.	
	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	tes:		I □ Yes	2 No	Specify:			Specif	y: Whi	to	
	15. Decedent's E	ducation		16a. Deced	lent's Us	ual Occup	ation	-	5 - 10 0	16b. Kind of B			
pie	(Specify only highest gra	ade completed)		(Give	kind of w	ork done o	during mos	t of worki	ing				
Completed 1	Elementary/Secondary (0-12) Oth grade	College (1-	4or 5+)	Stud	lout					N/A			
	Father's Name (First, Middle, Last	)		Sim	iem		18. Mothe	er's Name	(First, Middle.	Meiden Sumer	ne)		
0	John R. Prevette								ardwell				
		T - Dia		405 14 11		(0)					O+-+- T/-	0-4-1	
100	a. Informant's Name/Relationship (									er, City or Town		C000)	
	John Prevette (1	rather)	not p	1541			circl	.e,	Bel Air	-	1015		
20a	a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from S		emetery, crer	natory or	other plea	(e)	-	Date	20c. Location	- City or To	wn, Stata	
	4 □ Donation 5 □ Other (Special			en Mou	int (	crema	tory	6	/2/00	Baltin	ore.	Maryle	and
21.	. Signature of Funeral Service Lice	nsee		22	. Name a	nd Addre	ss of Facilit	ty					
g	1/1	1/1		So	chimi	inek	tuner	al H	ome of	Bel Air	Inc		
23	sa. Part1. Enter the disease, or com	polications that co	used the deet	Do not ent	or the mo	Mac de of dvin	Phace as	. KOA	a, bec	Air, N	10 21	014 Approximate	0
	shock, or heart lailure. List only	one cause on ea	ch line.	i. Do not on	01 (110 1110		9, 000, 00	04.0140	, roop.atory a			Interval Bet	ween
an Imr	mediate Cause (Final											1.1	
dis	sease or condition sulting in death)	a. Nic	Uti :	System	n C	rga	nF	a lu	we			Hour	5
	soluing in doubly		Due to (o	r as a consec	uence of	): (							
- e		5.	eptic	Sh	ock						i	Hour.	5
Examiner segments	quentially list conditions,		Due to (o	r as a conseq	uence of	):				-11		4537	
	quentially list conditions, any, leading to immediate use. Enter Underlying use (Disease or injury at initiated avents	13.	rain	Tiam	1						1	mont	Ls
Cai thai ras	of initiated avents sulting in death) Last	C.		as a conseq		):							
		d									1		
d by Physician	t II. Other significant conditions of	contributing to dea	th but not res	ulting in the u	nderlying	causa giv	en in Part I		23b. Did	tobacco uas co	ontributa to	the cause of	of death?
hy						-56			10	Y88 2 No	3□ Pro	bably 4 🗆	Unknown
by P													
9									24a. Was	an autopsy	24b. W	ere autopsy l	indings
0									perfo	rmed?	CO	ailable prior I mpletion of c	euse
etec											of	death?	
npieted				-40							0.		
Complete					A				1)医	Yas 2□No		Yes 2)2	No
Complete	Was case referred to medical						26. Place	e of Death	1 K			]Yes 2)⊠	No
99 OE	Was case referred to medicel examiner?	Hospitai: 1 🗷 In	patient 2	ER/Outpatier	nt 30 C	Oth Oth	or		n (Check only o		10		No
99 OE	examiner?  1 Yes 2 No  Manner of Death	28a. Date of	Injury	28b. Time of		JUA	er: 4 🗆 Nu	ursing Ho	n (Check only o	one)	1 [		,No
O Be Complete	examiner? 1 Yes 2 No	28a. Date of				28c. Injur Wor	er: 4 🗆 Nu	ursing Ho	n (Check only o	one) dence 6 🗆 Ot	1 [		,No
99 O O 25.	examiner?  1 Yes 2 No  Manner of Death  1 Natural 5 Pending investigatio 3 Suicide 6 Could not be	28a. Date of (Month)	Injury Day Year)	28b. Time of Injury	М	28c. Injur Wor 1 🗆	er: 4□ Nu yat k?	ursing Ho	me 5 Resi	dence 6 Other	1 [ her (Specif	y)	
99 OE	examiner?  1 Yes 2 No  Manner of Death  1 Natural 5 Pending investigation	28a. Date of (Month)	Injury Day Year)	28b. Time of Injury	М	28c. Injur Wor 1 🗆	er: 4□ Nu yat k?	ursing Ho	me 5 Resi	dence 6 Other	1 [ her (Specif	y)	
Complete Complete	examiner?  1 Yes 2 No  Manner of Death  1 Manural 5 Pending investigation  2 Accident investigation  3 Suicide 6 Could not be determined	28a. Date of (Month)	Injury , Day Year) of Injury - At hog, etc. (Specifi	28b. Time of Injury ome, larm, str	M eet, lacto	28c. Injur Wor 1 D	er: 4 Nu yat k? Yes 2	No	me 5 Resi 28d. Describe 281. Location ( City or Total	dence 6 Other occursions of the second occurs occurs on the second occurs occurs on the second occurs occurs on the second occurs occurs on the second occurs occurs on the second occurs occurs on the second occurs occurs occurs on the second occurs occurs on the second occurs occurs occurs on the second occurs occur	1 [ ther (Specifi rred ber or Rure	y) of Route Num	
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O Be Complete	examiner?    Yes   2 No     Manner of Death     Matural   5   Pending investigation     Accident   3   Suicide     Homicide   6   Could not be determined     Could not be	28a. Date of (Month) 28a. Place of buildin	Injury Day Year) of Injury - At hog, etc. (Specification)	28b. Time of Injury	M eet, lacto	28c. Injur Wor 1 D ry, office d at the tir n, in my o	y at k? Yes 2  me, date an pinion, dea	No No Add place, with occurr	me 5 Resi 28d. Describe 28l. Location ( City or Total	dence 6 Other thousing the second sec	1 E her (Specifiered ber or Rure anner as s and due to	y)  al Route Num  tated. b the cause(s	iber,
edical Certification: To Be	examiner?    Yes 2   No	28a. Date of (Month) 28a. Place of buildin	Injury Day Year) of Injury - At hog, etc. (Specification)	28b. Time of Injury	M eet, lacto	28c. Injur Wor 1 D ry, office d at the tir n, in my o	y at k? Yes 2  me, date an pinion, dea	No No Add place, with occurr	me 5 Resi 28d. Describe 28l. Location ( City or Total	dence 6 Othow injury occu  Street and Num  wn, State)  cause(s) and m  date and place,	1 E her (Specifiered ber or Rure anner as s and due to	y)  al Route Num  tated. b the cause(s	iber,
Wedical Certification: To Be Complete 227.	examiner?    Yes   2 No     Manner of Death	28a. Date of (Month) 28a. Place of buildin	Injury Day Year) Injury - At hose of my knoise of examina or stated.	28b. Time of Injury ome, larm, str/) wiedge, death tion and/or in	M seet, lactor occurre-vestigation 2	28c. Injur Wor 1 D ry, office d at the tir n, in my o	y at k? Yes 2  me, date an pinion, dea	No No Add place, with occurr	me 5 Resi 28d. Describe 28l. Location ( City or Total	dence 6 Othow injury occu  Street and Num  wn, State)  cause(s) and m  date and place,	1 E her (Specifiered ber or Rure anner as s and due to	y)  al Route Num  tated. b the cause(s	iber,
25. 27. 27. 29. 29. 29. 29. 29. 29. 29. 29. 29. 29	examiner?    Yes   2 No     Manner of Death	28a. Date of (Month) 28a. Place of building specials. To the barand manner.	Injury Day Year) Injury - At hose of my knoise of examina or stated.	28b. Time of Injury ome, larm, str./) wiedge, death tion and/or inv	M seet, lactor occurre-vestigation 2	28c. Injur Wor 1 Dry, office dat the time, in my o	y at k? Yes 2  me, date an pinion, dea	No No No	me 5 Resi 28d. Describe 28l. Location ( City or Total	dence 6 Othow injury occu  Street and Num  wn, State)  cause(s) and m  date and place,	1 E her (Specifiered ber or Rure anner as s and due to	y)  al Route Num  tated. b the cause(s	iber,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 31, 2000 3:10PM Francis Sidney Paine, Jr. MAY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner VAMHCS FORT HOWARD DIVISION FORT HOWARD BALTIMORE If Under 1 Yeer | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Hours 1√2 M 2□ F 078207028 Yrs Director 73 04/20/1927 New York Usuei Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Darlington Harford 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21034 Funeral 2067 Glen Cove Road 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yas 2 □ No If Yes, Give Year or Datas: 27 yrs. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours effer Department of Health and Mental Hygiene. Important: if Nem 27 la marked other than "natural", or then any Injury or other traumatic avent. the Medical Fermits. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S Navy Commander 4 years 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middle, Last) Be Francis Sidney Paine, Sr. 10 Florence Bowyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Elizabeth A. Paine- Wife P.O. Box 94, Darlington, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/5/00 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) R.A.Ferris & Co. Inc. 21. Signature of Funerel Service Licensee 22. Neme end Address of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 23a. Rarty. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one causa on each line. Approximate interval Batween Onset and Death **Physician** Medical Immediate Cause (Finel GLIOBLASTOMA MULTIFORME 3MONTHS diseasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disaase or injury that initiated evants resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Due to (or as e consequence of): use Po P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the detached 1 Yes 2 No 3 Probably 4 Unknown signed by PNEUMONIA Records. ģ 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed ALZHEIMER'S DEMENTIA has ARTERIOSCLEROTIC HEART DISEASE, ATRIAL FIBRILLATION 1 Yas 2 No 1 Yes 3 No Division of Vital Be 25. Was case referred to medical examinar? 26. Placa of Death (Check only one) Hospital: 1∑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral 28a. Date of Injury (Month, Dey Year) Hospital or Attanding Pi 124 hours after death.
 Funeral Director: After t 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by datarmined 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and due to the causa(s) and mannar as statad.

2 Medical Examtner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. Data signed (Month, Dey, Year) 29b. Signeture end fittle of certifier an

Registrar

State

S

9600 NORTH POINT RD. FORT HOWARD, MARYLAND

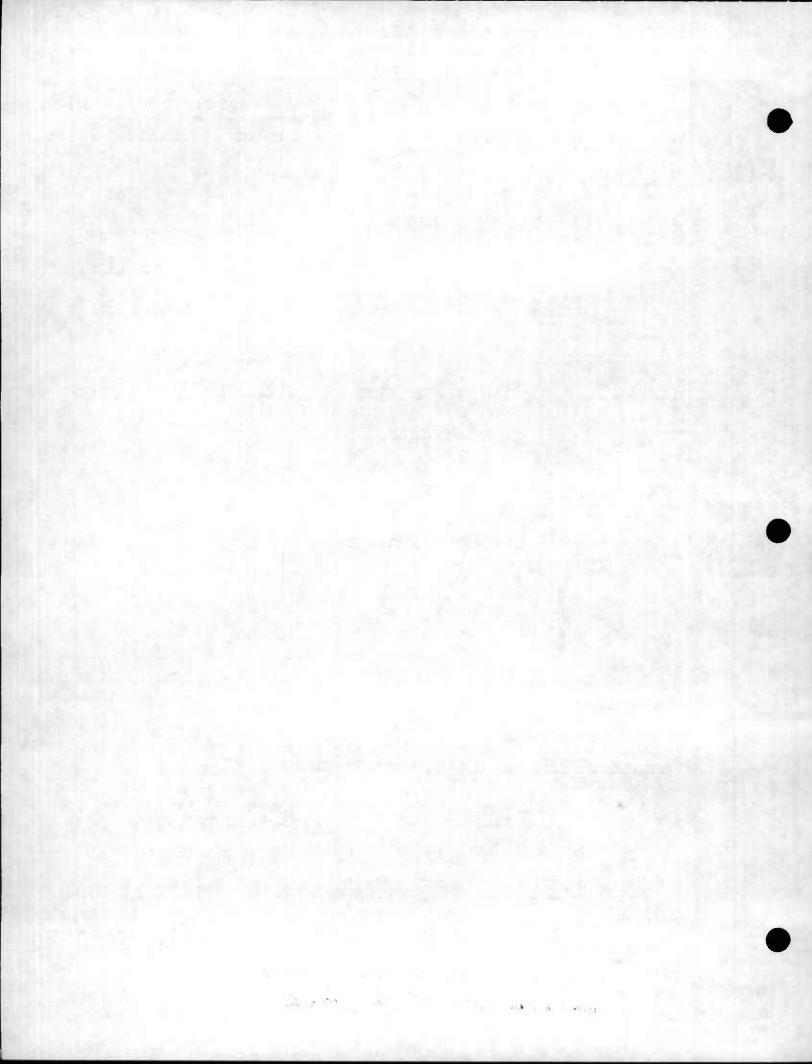
21052

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 0 2 2000

32. Registrár's Signature

AURORA C. TAN, MD 31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene 9382 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2000 Month **Physician** May 19, Fletcher Wright Pratt 8:15 p.m. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 34621 Cypress Road Millington Kent If Under 1 Year | If Under 24 Hrs. Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months XXM 20 F 89 Vre 217-36-1102 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. pernit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryle Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show en fujury or other treumatic event, the Medical Exemples must be notified at once. 1 ☐ Yes 2 No Director Millington Maryland Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34621 Cypress Road 21651 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: Saitimore, Maryland 21215-0020 1 Yes 20 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working Ma. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 2 Fletcher Pratt Addie Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean P. Edwards 34515 Cypress Road, Millington, MD 21651 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Data 1 X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Asbury Cemetery 5/24/2000 Millington, MD Funeral Service Licen 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A 370 W. Cypress Steet, Millington, MD 21651

Approximation each line.

Approximation and the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximation and the death. 23a. Part1. Enter the disease shock or heart failure. **Physician** 2 yeurs Immediate Causa (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner physicien end s the buriel-transit or Attending Physicien: The lew requires that the death certificate be exacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, 30 years or Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were autopsy lindings available prior to completion of cause of daath? 24a. Was an eutopsy performed? 1 Yes ZENo 1 Yes 2 No 25. Was case referred to medical 8 26. Place of Death (Check only one) 1 Yes THO Other: 4 Nursing Home Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred O Natural 5 Pending investigation deeth. 1 | Yes 2 | No To the Hospital or Attendi within 24 hours effer death To the Funeral Director: A completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) usan K, Chartestown md 2/620 516 Washing for 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State MAY 24 2000 Registrar

State of Maryland / Department of Health and Mental Hygiene

Physicia		1. Decedent's Neme (First, Midd	de, Last)	11					2. Dete of De Month	eth	Yeer	3. Time of Death		
/Medica	_	P.	AUL	JUNIO	DR I	PHIPPIN			June	2 200		10:11 a		
Examine	_	4e. Fecility Name (If not institution	on, give stree	et end numbe	1)			4b. Clty, Town, or			-			
		Dorches	ter Ge	eneral	Hospit	tal		Cambri	dae	Dor	chest	er		
ıneral	$\neg$	5. Sociel Security Number	6. Sex	7. A	ge (In yrs. le	st birthdey) If	Under 1 Yea	If Under 24 Hrs	8. Dete of Bir			lece (Stete or Fore		
rector	-	214-16-4699 Usuel Residence of Decedent	п≝м	2 F	75	Yrs.	onths Deys	Hours Min	Jan. 3		Mary			
N N		10e. State 10b. County	У		10c. City,	Town or Location	on				10	Od. Inside City Lim		
be notified at Director		MD Dor	cheste	er		Cambr	idge					1 <b>≸</b> Yes 2□1		
or 28a-f	e le	10e. Street end Number				1	Of. Zip Code			10g. Citizen of	Whet Coun	try?		
ant by	a	400 She	pherd	Ave.			21	613		U.S.	A.			
or thems 23a or 28a-f short miner must be notified at 7 Funeral Director		11. Maritel Status	12. V	Wes Deceden	t Ever in U,S	. 13. Wes	Decedent of	Hispenic Origin? (S ben, Mexican, Pue	Specify Yes or No	- 14. Rec	e - Americ			
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	0	Minus	S		Phip	pin			Viola	He	arn			
ment	-	19e. Informant's Name/Reletions	ship (Type, I	Print)		19b. Meiling A	dress (Stree	t end Number or R	ure/ Route Numb	er. City or Town.	Stete. Zip	Code)		
2 2		Mrs. Marjorie	Phippi	n-wife				Ave., C				,		
other o		20a. Method of Disposition	LI			ce of Dispositio			Dete	20c. Location		wn, Stete		
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mportant: If iny injury or zise.		21. Signeture of uneral Service			1001			cial Park						
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ician dical		Immediate Cause /Final										Onset end Deeth		
niner	- 1	Immediete Ceuse (Final disease or condition resulting in deeth)	θ	a	dult r	respirat	ory di	stress s	yndrome			2 weeks		
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s the	<b>D</b>	thet Initieted events resulting in deeth) Lest	1		Due to (or e	es e consequend	e of):				į			
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6.7	la la													
# o	Sign	Part II. Other significant condition	ons contribu	iting to death	but not result	ing In the under	ying cause g	iven in Pert I.	23b. Dld	lobacco use co	ntribute to	the cause of dea		
the attendir		gastrio	c canc	er					10	Yes 200 No	3 Prob	ably 4 Unkn		
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ate has been signed by the page 2 should be datached	Completed by	aspira	tion p						10	res 21 No	1 🗆	Yes 2□ No		
ertrificate has been signed by the ector, page 2 should be datached	be completed by	25. Was case referred to medica exeminer?	al	The st					1 🗆 v		1 🗆	]Yes 2□No		
nis certificate has been signed by the il director, paga 2 should be datached	to be completed by	25. Was case referred to medica exeminer? 1 □ Yes 2 No	al Hospi	ital: 1 Zimpat		-	LOOA	her: 4 Nursing I	eth (Check only o	ne) dence 6 □Oth	er (Specify			
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Committee of the committee of the state of t

**Physician** /Medical Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natures", or items 23 or 28=1 show eny injury or other traumatic event, the Modical Examination at mast be nounced at others.

**Physician** /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

				ink. Assure		_	ble.
	State of Mar	-	•	of Health and of Death		jiene	10 19384
1. Decedent's Nema (First, Middle, Last)	)				2. Date of Dea	th	3. Time of Death
Robert 1	Lester	Pis	011		Month 2	Dey	Year 1240
la Facility Neme (If not institution, give :		1 463	-4	4b. City, Town, or		7, 200 c	
PENINSULA REGION		CENTE	:R	SALIS	BIIRV		OMICO
5. Social Security Number 6. Sec		In yrs. last birt	thday) If Under		8. Dete of Birth		
221-16-60// 10	Mar all a	_	Yrs. Months	Days Hours Min.	June 2		Birthplaca (Stete or Foreign Country)
MD. Wicon.		Oc. City, Town	n or Location ruitle		1		10d. Inside City Limits 1 ☐ Yes 2 📉 No
	100						
Oe. Street and Number	10		10f, Zip (		1	Og. Citizen of V	
4020 Jose	ph Ur			21826		U.	S.A.
1. Marital Status	12. Wes Decedent Eve Armed Forces?	er in U,S.	13. Was Decede	ent of Hispanic Origin? (S ify Cuban, Mexican, Puar	specify Yes or No- to Rican, etc.)		e - American Indian, ck, White, etc.
1 Never Merried 2 Merried 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates: /9	51	1□Yes 2			Specify	
15. Decedent's Educ (Specify only highest grade	cation	16a.	Decedent's Usual	l Occupation k done during most of wo	dring	16b. Kind of Bu	usiness/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)	-	life. DO NOT use	e retired)	nary	0	
9			Diskn	rasher		Kes	taurant
7. Fether's Nema (First, Middle, Last)				18. Mother's Ne	me (First, Middle, I	_	
Otis David	Marshal	/		Gert	rude	Peac	ock
9e. Informent's Neme/Relationship (Type Alicia Zear		19b.		(Street and Number or R			
	1033	9	Disposition (Nam				
0a. Method of Disposition  1 ☐ Burial 2 ☑ Cremetion 3 ☐ R  4 ☐ Donetion 5 ☐ Other (Specify)		cemeter	y, cremetory or other	herplace)			City or Town, State Lurch Va.
21. Signeture of Funaral Sarvice License	egar Emde	Baly	Salye	Address of Fecility  Funeral	Home 63	27 Chui	rch ST.
23a. Pert1. Enter the diseese, or compli- shock, or heert feilure. List only on	ications thet caused the cause on each line.	e death. Do n	ot enter the mode	of dying, such es cardia	c or respiretory err	est,	Approximete tnterval Between Onset and Deeth
Immediete Ceuse (Finel diseese or condition	Acy		M. I.		- 1100		5 Days
resulting in death)		o to for ac a c	consequence of):				1-
	CMI		consequence or).				5 Days
Sequentially list conditions,	CHI	-	consequence of):				5 Days
Sequentially list conditions, any, leading to immediate ause. Enter Underlying	CHF	e to (or as a c	consequence of):				5 Days
Sequentially list conditions, any, leading to immediate ause. Enter Underlying Jause (Disease or injury hat initiated events	Puu	e to (or as a c	consequence of):				5 Day
Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause. (Disease or injury ast initiated events	Puu	e to (or as a c	consequence of):				5 Days
iequentially list conditions, any, leading to immediate ause. Enter Underlying ause. (Disease or injury at initiated events	Puu	e to (or as a c	consequence of):				5 Days
Sequentially list conditions, any, leading to immediate ause. Enter Underlying Lause (Disease or injury hat initiated events esulting in death) Last	Du CHE	ee to (or as a c	consequence of):				5 Days
Sequentially list conditions, lany, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last	Du P UU Du d	e to (or as a c	consequence of):  Officers of the underlying ca		23b. Did to		
Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last	Du P UU Du d	e to (or as a c	consequence of):  Officers of the underlying ca			es 2 No	3 Probably 4 Unknow  24b. Were autopsy findings aveilable prior to
dequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Dissesse or injury lat initialed events assulting in death) Last	Du P UU Du d	e to (or as a c	consequence of):  Officers of the underlying ca		24a. Wes a	in autopsy med?	3 Probably 4 Unknow
Gequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initialed events esulting in death) Last  ert II. Other algorificant conditions con  METAS FA	Du P UU Du d	e to (or as a c	consequence of):  Officers of the underlying ca	= Cq.	24a. Wes a perform	en autopsy med?	3 Probably 4 Unknow  24b. Were autopsy findings aveilable prior to completion of cause of death?
Sequentially list conditions, lany, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last  Pert II. Other algorificant conditions con  METAS FAC	Du P LLL Du Du dt.	e to (or as a c	consequence of):  Of disconsequence of):  In the underlying ca	26. Place of De	24a. Wes a perion	en autopsy med?	3 Probably 4 Unknow  24b. Were autopsy findings aveilable prior to completion of cause of death?  1 Yes 2 No
Sequentially list conditions, lany, leading to immediate ause. Enter Underlying acuse (Disease or injury hat initiated events esulting in death) Last  Pert II. Other algorificant conditions con COPD  15. Was case referred to medical axeminer?  1 Yes 2 No	Du CHE  Du  CHE  Du  CHE  Du  CHE  Du  Du  CHE  Du  Du  Du  Du  Du  Du  Du  Du  Du  D	e to (or as a control of the control	consequence of):  NIA consequence of):  In the underlying ca	26. Place of De	24a. Wes a perion  1 Yes	in autopsy med?	3 Probably 4 Unknow  24b. Were autopsy findings aveilable prior to completion of cause of death?  1 Yes 2 No
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intieted events resulting in death) Last  Pert II. Other algorificant conditions con  MEHG S For  COPY  25. Was case referred to medical axeminer?	Du P LLL Du Du dt.	e to (or as a control of the control	consequence of):  NIA consequence of):  In the underlying ca	26. Place of De	24a. Wes a perform	in autopsy med?  es 2 No ne) ence 6 Oth ow injury occurr	24b. Were autopsy findings aveilable prior to completion of cause of death?  1 □ Yes 2 □ No

Medical Certification: To Be Completed by Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

State Registrar

29b. Signeture end title of certified

31. Data filed (Month, Dey, Year)

MAY 3 0 2000 MOINDEA

moved al

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

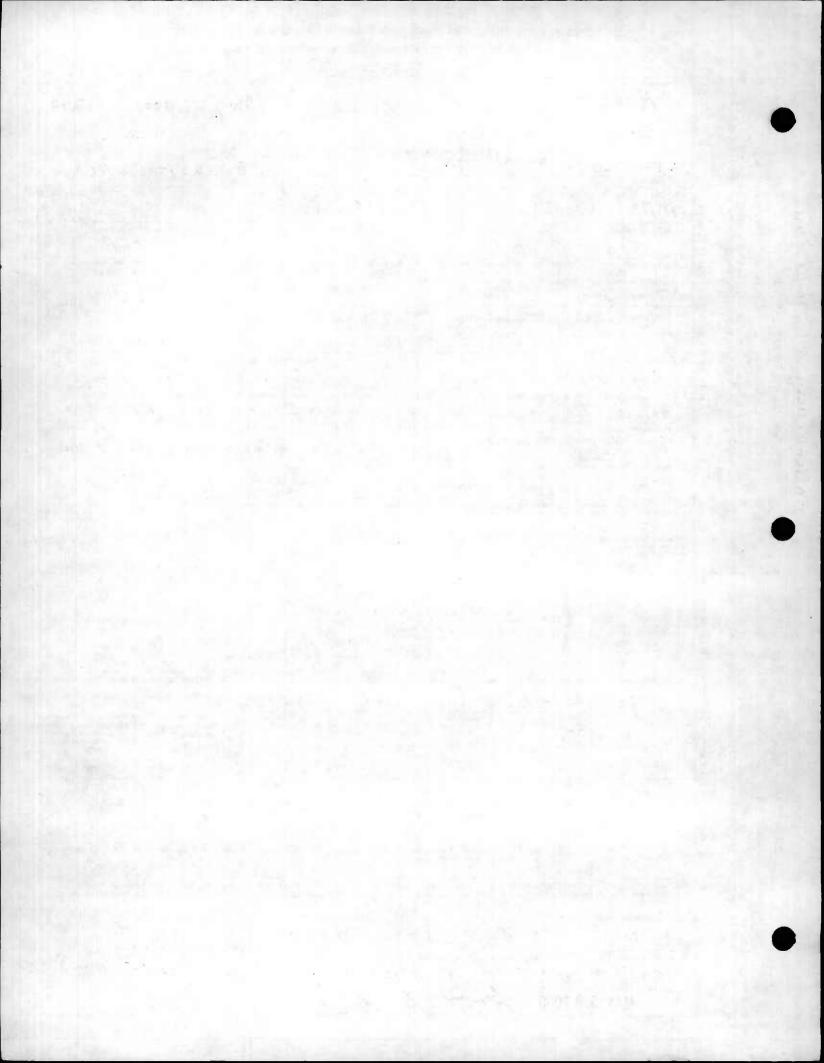
32. Régistrer's Signature

106 MILPORD ST SOUB Salsaury as 2784

29c. License number

32014

29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month **Physician** Ludwell Compton Quade June 6, 2000 2:10 A.M. /Medical 4a Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Harbour Inn Convalescent Center Baltimore If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) 5. Social Security Number If Under 1 Yeer Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1₩ M 2□ F Deys Months 579-14-6153 84 July 28,1915 Washington, Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yas XXNo Funeral Director Maryland Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 886 Chinquapin Crest Drive 20776 238 USA death Hems: 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. filed within 72 hours efter 1 Never Merried 2 Merried 6 21215-0020 1 Yes 2 No Specify: Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Driver Pharmacy permit, Peges 1 and 2 should be fife
Department of Health and Mental Hy
Important: If Nem 27 Is marked othe
any Injury or other transmented other Maryland 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be John Bruce Quade Ella Lucinda Bennett 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Kathleen B. Keely/ Daughter 886 Chinquapin Crest Drive Harwood, MD 20776 Saltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Buriel 2 XX remetion 3 ☐ Removel from State Metropolitan Crematory 4 Donetion 5 Other (Specify) 6-6-00 Alexandria, Virginia 22. Name end Address of Fecility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. P\$11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final JAUNDICE OBSTRUCTIVE WEEKS disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner WEEKS CARCINOMA OF DUCT The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last burial-tran Due to (or as a consequenca of) and Box 68760. Physician/Medical the Due to (or es e consequence of): 60 USB a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Onknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed page 2 s certificate hes 1 Yes 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: funeral director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Division Netural s after death.

I Director: Aft din by the fur 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) illed in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end menner stated. 29a. Certifier pletely 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end Alle of certifier asantha kuma Mp D42510

State Registrar 31. Dete filed (Month, Dey, Year)

JUN 0 7 2000

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

\*\*VASPNTUP KUM AL GUI: VASANTUR KUMAN 32. Registrer's Signeture

821. NEUTAW ST SUITE 407,

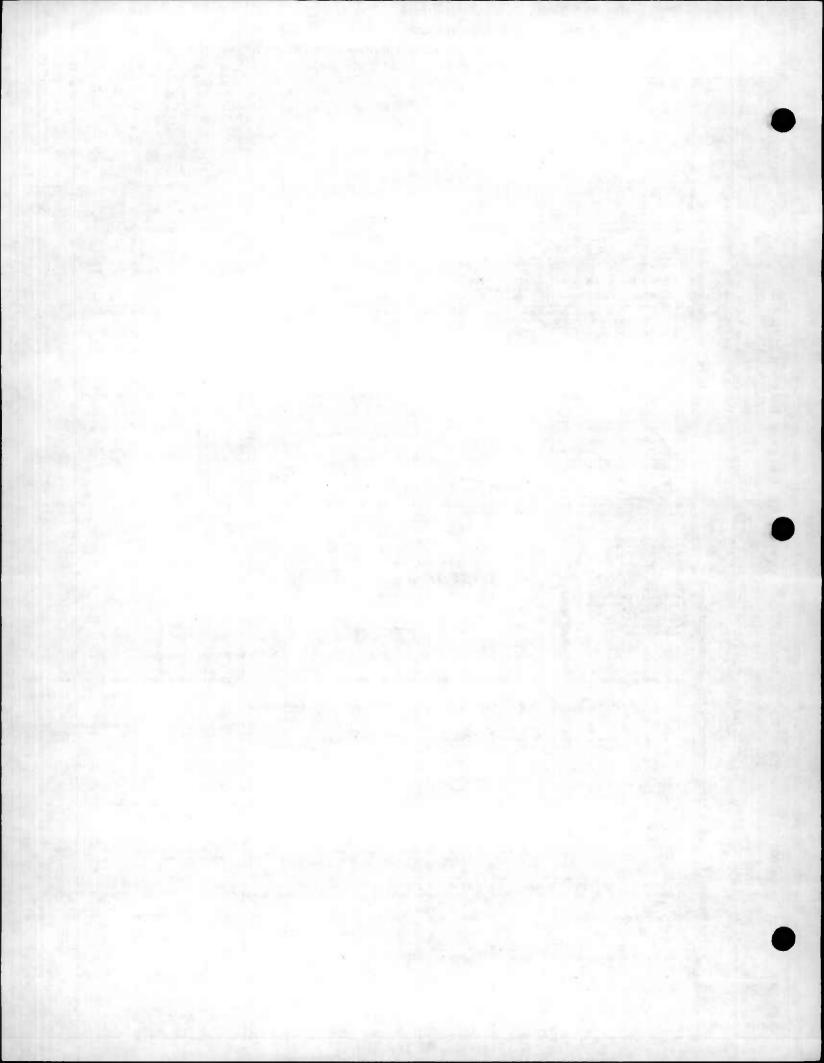
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RECORD  ROY  ROY  ROY  ROY  ROY  ROY  ROY	Physician		ne (First, Middle	a, Last)					2. Data of D Month	Death Day	Year 3. Time of D	
Control   Cont						R	.OY					
S. Social Society Number  1077—307—6611  Usual Residence of Discociety  1087—17—307—6611  Usual Residence of Discociety  108. Size of Policy Number  108. Size of Policy Number  109. Size of Policy	Examiner	4a Facility Nama (	(If not institution	n, give street and	number)		4b. City, Town, o			th 4c. County	of Death	
The state of the					-							
100. Clark   100. Comby   100. Clark   100		217-30-8	611						(Month, E	Dav. Year)	9. Birthplace (State or F Country) Virginia	
23104 Baywood Ct., Apt. 15A   12 Was Deceded Earl II U.S.   13 Was Deceded to Hispanic Crigin? (Specify Yes or No. 1948 as possibly Ciden. Machina, Sec.)   14 Race - American Indian, Black Was as a Consequent of Hispanic Crigin? (Specify Yes or No. 10 Was 10	B W	10a. Slata			10	c. City, Town or I	Location					
A	cto the	Maryland	Kent			Cheste	rtown				1 ☐ Yes 2	
23104 Baywood Ct., Apt. 15A   12 Was Deceded Earl II U.S.   13 Was Deceded to Hispanic Crigin? (Specify Yes or No. 1948 as possibly Ciden. Machina, Sec.)   14 Race - American Indian, Black Was as a Consequent of Hispanic Crigin? (Specify Yes or No. 10 Was 10	or 2	10e. Street and Nu	mber				10f. Zip Code			10g. Citizen of V	What Country?	
10   10   10   10   10   10   10   10	ant b	23164 Ba	ywood C	Ct., Apt.	. 15A		21620			USA		
15. Decedent Stuciation   16. Decedent Stu	Pr 101			ied 1 🗆 Ya	s 2 No Giva	r in U,S. 13			Specify Yes or N to Rican, atc.)		ck, Whita, atc.	
190. Nating Address (Sizeet and Number of Rural Rouse Number, City or Town, State, 20 Code)  Mary Roy / wife  200. Mallord Objection 11 Migurial 2 (Caramation 3 Demoval from State 12 (Donation 6: Donat (Speech) 21 Signature of Funeral Service Licensee  21 Signature of Funeral Service Licensee  22 Name and Address of Facility 22 Name and Address of Facility 23 Name and Address of Facility 24 Name and Address of Facility 25 Name and Address of Facility 26 Name of Department of Funeral Service Licensee  25 Name and Address of Facility 26 Name of Department of Funeral Service Licensee  25 Name of Service Licensee  26 Name of Service Licensee  27 Name of Cause (Final disease)  28 Part License (Final disease)  29 Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Address (Descard of Licensee)  26 Name of Cause (Final disease)  27 Name of Cause (Final disease)  28 Requested of Cause (Final disease)  29 Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Address (Descard of Licensee)  28 Name of Cause (Final disease)  29 Due to (or as a consequence of):  Consequence of Cause (Final disease)  20 Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Consequence of Cause (Final disease)  20 Due to (or as a consequence of):  Consequence of Cause (Final disease)  21 Due to (or as a consequence of):  Consequence of Cause (Final disease)  22 Due to (or as a consequence of):  Consequence of Cause (Final disease)  23 Due to (or as a consequence of):  Consequence of Cause (Final disease)  24 Due to (or as a consequence of):  Consequence of Cause (Final disease)  25 Due to (or as a consequence of):  Consequence of Cause (Final disease)  Consequence of Cause (Final disease)  Consequen	and bet		15. Decedent	r's Education		16a. Dec	edent's Usuel Occup	pation		16b. Kind of Br		
199. Informaris \ NamePalationship \ (Type, Print) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ole ole	(Spec	-			(Giv	e kind of work done DO NOT use retire	during most of wo d)	rking		100000	
199. Informaris \ NamePalationship \ (Type, Print) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	4 E	4	oridary (0-12)	College	9 (1-40( 5+)	Jan	itor			Corn	Factory	
190. Informaris's Name-Relationship (Type, Print)  190. Valing Address (Sireet and Number of Rural Rouse Number, Cay or Town, State, 20 Code)  Mary Roy / wife  200. Place of Disposition (Numan or Number, Cay or Town, State, 20 Code)  190. Wallord Of Disposition 11 Mighard 2 (Charaction 3) Elemonal from State 200. Place of Disposition (Numan or Number, Carried Place) 15 / 19 / 2000 Chestertown, Mary 21. Signature of Funeral Sanice Ucensee  21. Signature of Funeral Sanice Ucensee  22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 35 / 19 / 2000 Chestertown, Mary 25. Name and Address of Facility 36 / 19 / 2000 Chestertown, Mary 36 / 19 / 2000 Chestertown, Mary 37 / 2000 Chestertown, Mary 38 / 2000 Chestertown, Mary 38 / 2000 Chestertown, Mary 38 / 2000 Chestertown, Mary 38 / 2000 Chestertown, Mary 38 / 2000 Chestertown, Mary 39 / 2000 Chestertown, Mary 30 / 2000 Chestertown, Mary 30 / 2000 Chestertown, Mary 30 / 2000 Chestertown, Mary 30 / 2000 Chestertown, Mary 30 / 2000 Chestertown, Mary 30 / 2000 Chestertown, Mary 30 / 2000 Chestertown, Mary 30 / 2000 Chestertown, Mary 30 / 2000 Chestertown, Mary 30 / 2000 Chestertown, Mary 30 / 2000 Chestertown, Mary 30 / 2000 Chestertown, Mary 31 / 2000 Chestertown, Mary 32 / 2000 Chestertown, Mary 32 / 2000 Chestertown, Mary 32 / 2000 Chestertown, Mary 32 / 2000 Chestertown, Mary 32 / 2000 Chestertown, Mary 32 / 2000 Chestertown, Mary 32 / 2000 Chestertown, Mary 32 / 2000 Chestertown, Mary 32 / 2000 Chestertown, Mary 32 / 2000 Chestertown, Mary 32 / 2000 Chestertown, Mary 32 / 2000 Chestertown, Mary 32 / 2000 Chestertown, Mary 33 / 2000 Chestertown, Mary 34 / 2000 Chestertown, Mary 35 / 2000 Chestertown, Mary 36 / 2000 Chestertown, Mary 37 / 2000 Chestertown, Mary 38 / 2000 Chestertown, Mary 38 / 2000 Chestertown, Mary 39 / 2000 Chestertown, Mary 30 / 2000 Chestertown, Mary 30 / 2000 Chestertown,	ent,	17. Falhar's Nama	(First, Middla, i	Last)				18. Mother's Nar	ma (First, Middle			
190. Nating Address (Sizeet and Number of Rural Rouse Number, City or Town, State, 20 Code)  Mary Roy / wife  200. Mallord Objection 11 Migurial 2 (Caramation 3 Demoval from State 12 (Donation 6: Donat (Speech) 21 Signature of Funeral Service Licensee  21 Signature of Funeral Service Licensee  22 Name and Address of Facility 22 Name and Address of Facility 23 Name and Address of Facility 24 Name and Address of Facility 25 Name and Address of Facility 26 Name of Department of Funeral Service Licensee  25 Name and Address of Facility 26 Name of Department of Funeral Service Licensee  25 Name of Service Licensee  26 Name of Service Licensee  27 Name of Cause (Final disease)  28 Part License (Final disease)  29 Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Address (Descard of Licensee)  26 Name of Cause (Final disease)  27 Name of Cause (Final disease)  28 Requested of Cause (Final disease)  29 Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Address (Descard of Licensee)  28 Name of Cause (Final disease)  29 Due to (or as a consequence of):  Consequence of Cause (Final disease)  20 Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Consequence of Cause (Final disease)  20 Due to (or as a consequence of):  Consequence of Cause (Final disease)  21 Due to (or as a consequence of):  Consequence of Cause (Final disease)  22 Due to (or as a consequence of):  Consequence of Cause (Final disease)  23 Due to (or as a consequence of):  Consequence of Cause (Final disease)  24 Due to (or as a consequence of):  Consequence of Cause (Final disease)  25 Due to (or as a consequence of):  Consequence of Cause (Final disease)  Consequence of Cause (Final disease)  Consequen	D . 0	Luke			Ro	37		Emmo	I.I.o.	1 kor		
Mary Roy / wife 23164 Baywood Ct., Apt.15A, Chestertown, Md.21620  20a. Majbord of Disposition   Date   20a. Location - City or Town, State   Concept   Date   20a. Location - City or Town, State   Concept   Date   20a. Location - City or Town, State   Concept   Date   20a. Location - City or Town, State   Concept   Date   20a. Location - City or Town, State   Concept   Date   20a. Location - City or Town, State   Concept   Date   20a. Location - City or Town, State   Concept   Date   Concept   Date   Concept   Date   Concept   Date   Concept   Date   Concept   Date   Da	THE P		and Malakin at	tin Grand Briefl	NO.						0.77 = 0.41	
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A   Oceation S   Other (Speech)   Other   Came Class   15/19/20   Ochestertown, Mary   21. Signature of Funerial Service Licensees   22. Names and Address of Facility   22. Names and Address of Facility   23. Names and Address of Facility   24. Names and Address of Facility   25. Names of Ocean   25. Names and Address of Facility   25. Names of Ocean   25. Names and Ocean   25. Names of Ocean   25. Names of Ocean   25. Names of Ocean   25. Names of Ocean   25. Names of Ocean   25. Names of Ocean   25. Names of Ocean   25. Names of Ocean   25. Names of Ocean   25. Names of Ocean   25. Names of Ocea	or to			3 Removal fro		cematery, cri	ematory or other pla	ce)	Date	20c. Location -	- City or Town, Stata	
22. Signature of Funeral Service Licensee  22. Signature of Funeral Home P.O. Box 1687, Easton, Maryland 21601  23a. Part Letter This disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Immediate Cause (Final disease) or complications are caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Immediate Cause (Final disease) or complications are caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Immediate Cause (Final disease) or condition rasuling in death) literature. Due to (or as a consequence of):   Due to (or as a consequ	ory or				an otato	New Chr	istian Ch	tery 5/19/2000 Chestertown, N				
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27. Manner of Death   2   Accident   2   Accident   3   Suicida   4   Homicide   5   Pending invastigation   28a. Data of Injury   28b. Tima of Injury   M   1   Yes 2   No    28a. Place of Injury - At homa, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number of Town, State)  29a. Cartifier (Check only one)   29a. Cartifier (Check only one)   29a. Cartifier (Check only one)   29a. Signature and title of certifier   29a. Signature and title of certifier   29a. Date signed (Month, Day, Year)   28b. Tima of Injury   M   1   Yes 2   No   28d. Describe how injury occurred   28d. Describe how injury occurre	ate has been signed by the eltending physician and page 2 should be detached for use as the burial-transit.  Completed by Physician/Medical Examiner	Sequentially list co if any, leading to in cause. Enlar Unde Causa (Disease or that initiated avents rasulting in death)  Part II. Other signification  Court	inditions, nadiata styling injury s. Lasi	d	Peripo death but no	to (or as a conse	very Velson vels	on in Part I.  y Aisean	23b. Dic 1E 24a. Wa per	1 tobacco use coo	Onset and De	
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29a. Cartifiar (Check only one)  29a. Cartifiar (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the lima, data and place, end due to the cause(s) and manner as stated.  29a. Cartifiar (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  5/19/00	ther this certificate has been signed by the estending physician and uneral director, page 2 should be detached for use as the burial-transit on: To Be Completed by Physician/Medical Examiner	rasulting in death)  Sequentially list co if any, leading to in cause. Enlar Unda Causa (Disease or that Initiated avents rasulting in death)  Part II. Other significance of the country	anditions, madiata artying Injury s Last  Scale Conditions  Scale Conditions  Scale Conditions  Scale Conditions  Scale Conditions  Scale Conditions  Tead to medical Tead to medical Tead to medical Invastignity assignity assig	d.  d.  na contributing to O Bs 72  Hospital: 18  28a. Date (Mr.	Peripode death but not be death but not	to (or as a consecutive of resulting in the function of the fu	ep Velucione of):  Varcuel  underlying causa gh  ulucione  Afres  ent 3 DOA Otto	yen in Part I.  yen in Part I.  y Acaesa  26. Place of Dei  1007: 4 Nursing H  yel  th?	23b. Dic 1E 24a. Wa per 1 ath (Check only	1 tobacco use coo	Onset and De	
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DHMH 16 Rev 6/95



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yaaı **Physician** 150m 2000 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Facility Nema (If pot institution, give street and number) Examiner MARY ems 1 Anc fimial unuens: Leavers OTI If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yaar 8. Dete of Birth (Month, Day, Year) Feb. 2, 1927 Birthpleca (Stete or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 M 2 KF 218-30-2285 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 25a-f show with the Maryla the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Talbot Easton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or USA Unionville 21601 Funeral Road Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, 11 Marital Status Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Datas: 1 M Never Merried 2 ☐ Merried 21215-0020 1 ☐ Yes 2 No Specify by Specify. 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry other than Elementary/Secondery (0-12) College (1-4or 5+) Unknown Unknown Baltimore, Maryland 18. Mother's Nama (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middla, Last) å Health and Mental om 27 is markad o Marie Roberts Smith James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 26896 Tunis Mill Rd., Easton, Maryland 21601 Deanna Roberts / Daughter Department of Health Important: If Item 27 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Crametion 3 ☐ Removal from Stata 5/27/2000 Dover, Delaware 4 ☐ Donation 5 ☐ Othar (Specify) Capitol Crematory 22 Nama end Address of Fecility Bennie Smith Funeral Home 21. Signeture of Funerel Service Licensee P.O.Box 1687, Easton, Maryland 21601 23a. Pert1. Enter the disease, or complications that exceed the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be axecuted attending physician and for use as the bunal-tran Sequantielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 ue to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by by of Vital Records, oltal or Attending Physician: The law require ours after death. eath Director: After this certificate has been si filled in by the funeral director, page 2 should I 24e. Wes an autopsy performed? 24b. Wera eutopsy findings available prior to completion of causa of daeth? Be Completed 2 No 1 Yas 2 NO 25. Was case raferred to medical axaminar? 26. Placa of Death (Check only one) Hospitel: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how injury occurred Division 1 Natural 2 Accidant 5 Pending investigation 1 Yes 2 No 28f. Location (Straat end Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Sulcida 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 \( \text{Homicide} \) To the Hospital o within 24 hours al To the Funeral D 29a. Certifier DRI Cartiful completely 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end

State Registrar 30. Name and eddress of p

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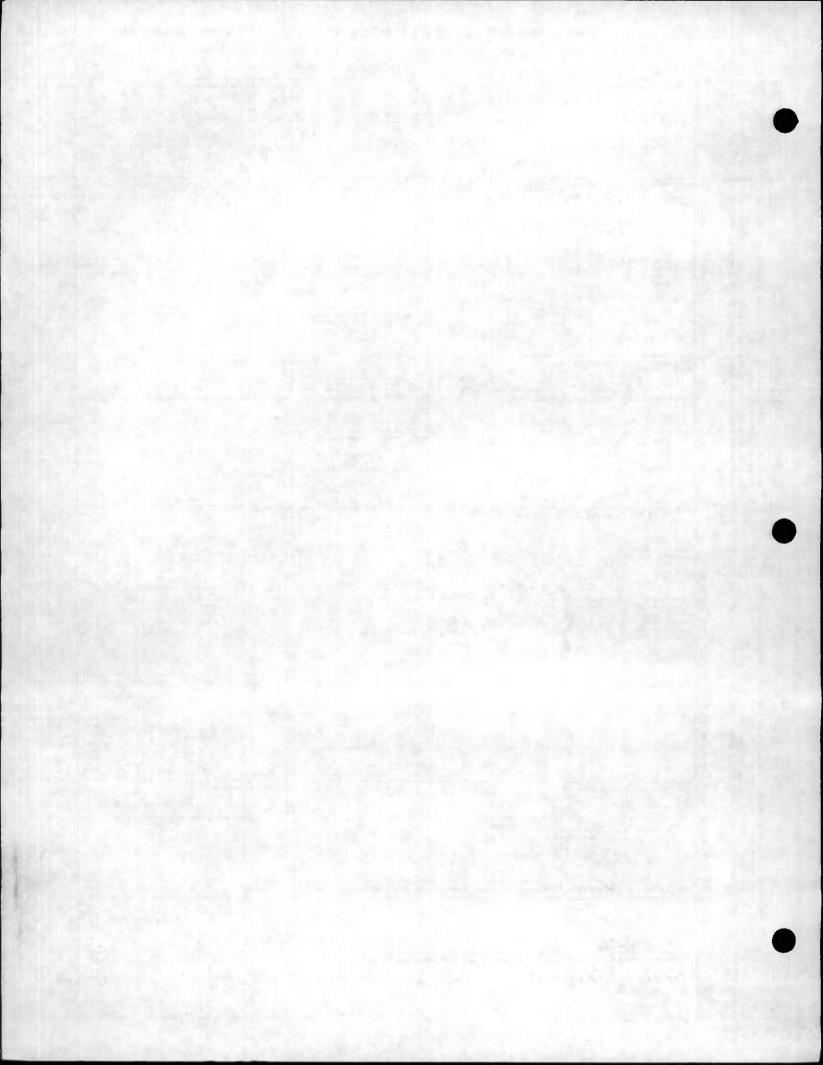
DHMH 16 Rev 6/95

ORIGINAL

on who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

22



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Deeth

1. Decedent's Neme (First, Middle, Last) MAY **Physician** HELEN MARSHALL ROSAN 23 2000 6:10am /Medical 4e Facility Name (ff not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14001 Augustine Herman Hwy Kent Georgetown | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | July 23 1910 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpiece (State or Foreign **Funeral** 10 M 20 F 89 New York 062-07-8770 Director Usual Residence of Decedent death with the Mandand 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits ehow mast be notified at Yes 2 No Director MD Kent Georgetown 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 14001 Augustine Herman Hwy 21930 or Herna 23a U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, Whita, atc. 11. Merital Stetus filed within 72 hours effer 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2X No Specify: White p Specify: 3 Widowed 4 Divorced Year or Dates: Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home permit. Peges 1 end 2 should be fille.
Deperment of Health end Mental Hygi Important: If item 27 is marked any hiury or other the Mental Hygi Received. Saitimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Be Samuel A. Marshall Anna T. Carpenter 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Rosan (husband) P.O. Box 177 Georgetown, MD. 21930 20b. Plece of Disposition (Neme of Date 20c. Location - City or Town, Stete 20e. Method of Disposition cemetery, cremetory or other plecel 1 Burial 2 Cremation 3 Removal from Stete Capitol Crematory 5/24/00 Dover, DE. 4 Donetion 5 Other (Specify) 21. Signature of Funged Service Ligarisa 22. Name and Address of Fecility Galena Funeral Home of Stephen Schaech M00510 118 West Cross St. Galena, MD. 21635 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or healt failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical erons eriosc Examiner Due to (or es e consequance of): Completed by Physician/Medical Examiner the buriel-transit The lew requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or es a consequence of): Box 68760, physician Due to (or as a consequence of) for use as P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vitai Records. 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? V015V After this certificate hes 1 ☐ Yes 2 ☐ No 1 Yes 2 No ours after death.

eral Director: After this certifica filled in by the funeral director, f or Attending Physician: 25. Was cese referred to medical Medicai Certification: To Be 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/OutpatienI 3 ☐ DOA Other: 4 Nursing Home 5XX Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rurel Roufe Number, City or Town, Stefe) 3 Suicide 28e. Plece of Injury - At home, farm, straet, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier completely 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (Qr ann 2 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 21620 Wayne D. Benjamin MD 6602 Church Hill Rd. Suite 200 Chestertown, MD

**DHMH 16 Rev 6/95** 

State

Registrar

31. Dete filed (Month, Day, Year)

MAY 24 ZU

32/Registrar's Signeture

MAY 2 4 2000 Person D. Caram

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Mildred Roberts 2330 MAT 26, 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb 23, 19 Birthplace (State or Foreign Country) VA 1 M 2 KF 219-14-4094 77 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Wicomico 1 □XYas 2 □ No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 954 Gateway Village 21801 U.S. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yea, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yas 2X No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 31€ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Uaual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maid 8th Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Rev. George Burton Hattie Brickhouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) Dorothy Ann Lively/daughter 113 Gunby St., Snow Hill, MD 21863 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State Green Acres Mem Park 6/2/2000 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 234 Part1. Enler the disease, or complications that caused the death. Do not enler the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximele Interval Batwean Onset end Death Immediate Cause (Final LUNG CANCIN OMA (NetZes disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted eventa resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yae 2 No 3 Probably 4 TUnknown MYELOPYSPLASIA. 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑1npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 PNatural 1 | Yes 2 | No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Records, Division of Vital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Name 23a or 28a-f short

21215-0020

Maryland

altimore,

450K-1005

1030

Health and Mental Hydiana

Pages 1 and 2 should

Repartment of Health Important: If Nem 27

**Physician** /Medical

Examiner

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this certificate has rai director, page 2

funeral director,

Physician/Medical

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Completed

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Certification: To

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Director

Funeral

To the Hospital or Attending Phi within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RENEE DESON THIS 31. Date filed (Month, Day, Year) MAY 3 0 2000 State

29b. Signature and title of certifie

29e. Certifier (Check only one)

32. Redistrar's Signature

SHORE TH

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

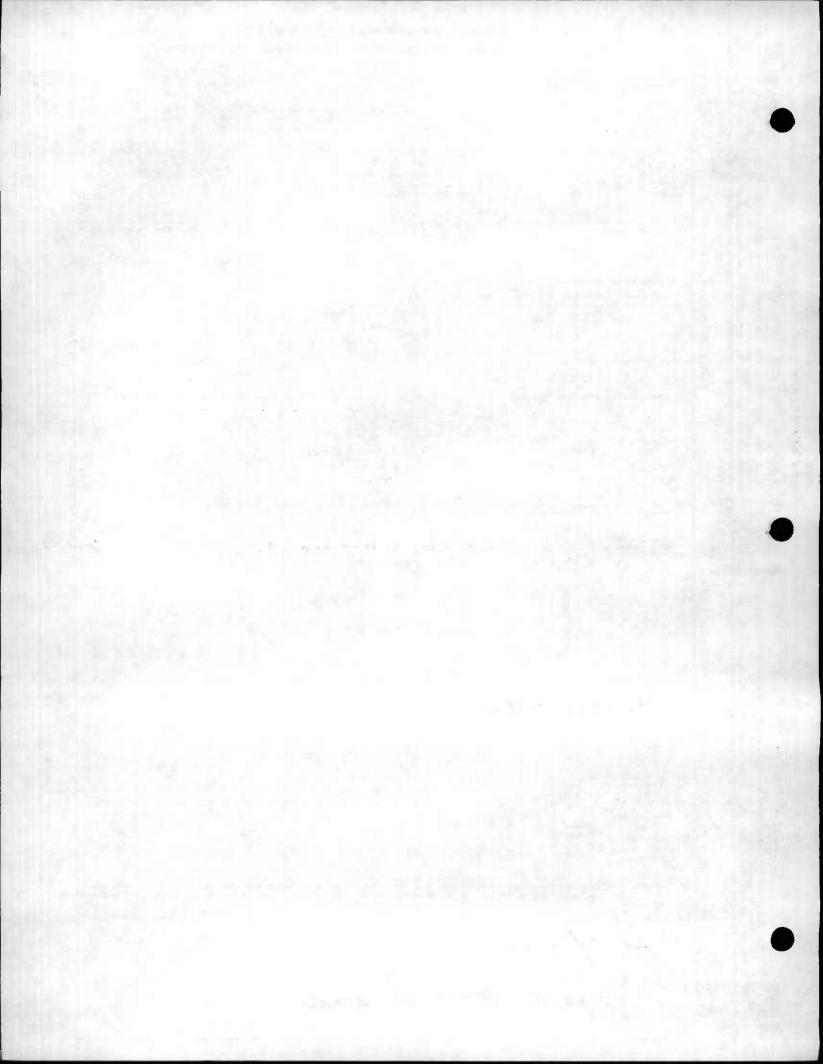
29c. License number

43835

29d. Date signed (Month, Dey, Year) 5/26/00

Southuny, mi 21801 YW ESTERN

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician DOROTHY HENRY ROBBINS 28, 2000 MAY 0344 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. Hours | Min. If Under 1 Year Morstha Days B. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 M 2CXF Director 220-01-3631 July 1, 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2KINo Director Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10126 Henry Road 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 25 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hace - American Indian, Black, White, etc. 1 T Never Married 2 T Married 1 Yes 2KINo Specify: Specify: 3 XWidowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th laborer/domestic Ocean Mecca Hotel permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Nem 27 is merked other any Injury or other traumatic event abbs. 17. Father's Name (First, Mickillo, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John (Jack) Showell Maggie Selena Henry 19a. Informant's Name/Fielationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Omega Black/niece 10126 Henry Road - Berlin, Maryland 21811 20s. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) New Bethel Church Cemet. 6/03/00 | Berlin, Maryland 21. Signatury of Funeral Service Liceto 22 Name and Address of Facility 1213 Jersey Road - Salisbury, MD wella JOLLEY MEMORIAL CHAPEL 21801 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Physician Cerebral Hemoresta /Medical mediate Cause (Final lease or condition sulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events t initiated events sulting in death) Last Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? PANKINIONY 3 Probably 4 Unknown 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To 27. Magner of Deat 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Accident 1∐Yes 2∐No investigation 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28s. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 41 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature as d title of cort 29c. License number 29d. Daty signed (Month, Day, Year) 00 Skitting Julius 31. Date Held (Month, Day Ye

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To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atte completely filled in by the fun

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Division of Vital Attending Physician:

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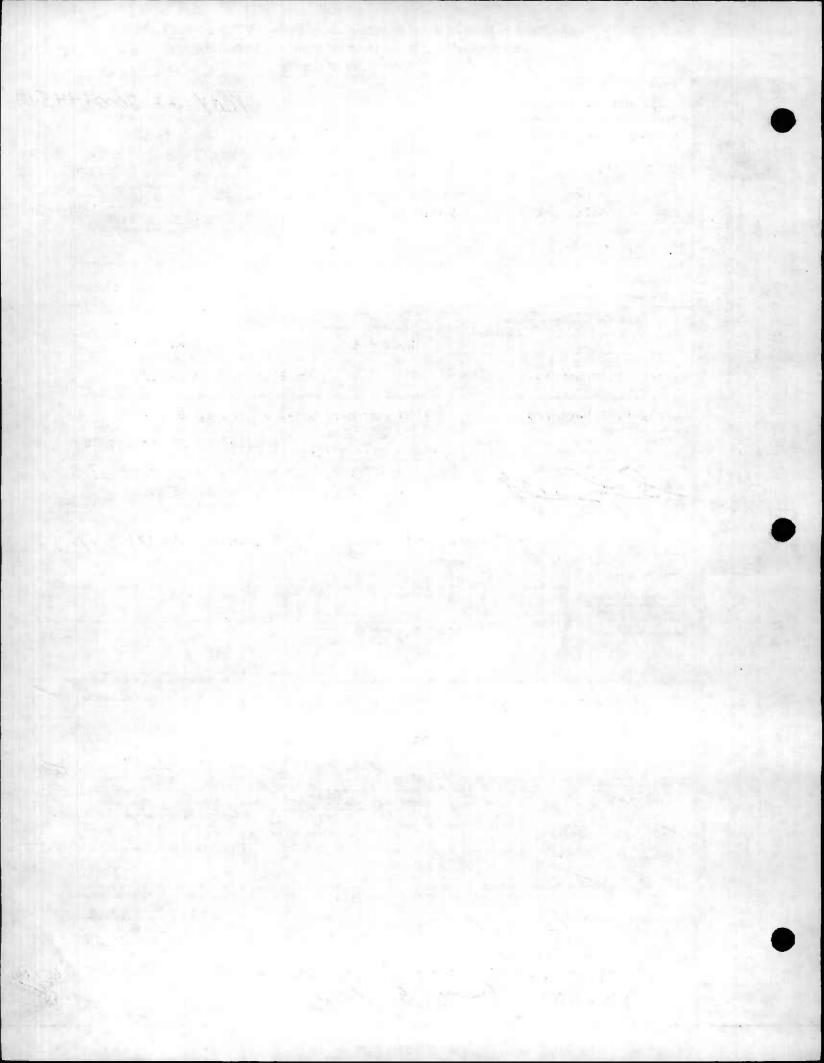
State Registrar

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**DHMH 16 Rev 6/95** 

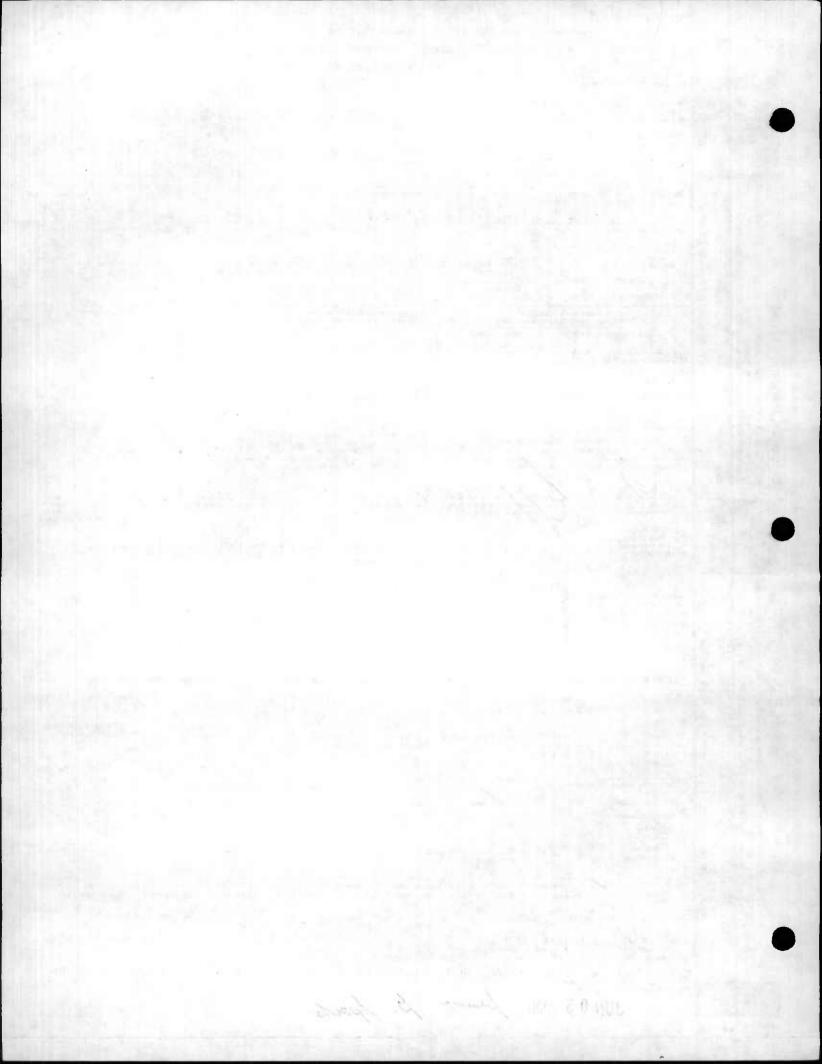
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2000 1445 PM **Physician** Frances E. Roberts /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Brightwood Eldercare Center Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 1 /27/1909 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10M 20F Months 91 Director 222-32-3541 Delaware Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show il Hygiene. other than "natural", or itema 23a or 28a-f shov vent, the Medical Exeminar must be notified at NO Yes 2 No Director MD Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? flied within 72 hours effer deeth with 9110 Lennings Lane 21237 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white à 3 Nidowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home permit. Peges 1 and 2 should be filt Department of Health and Mentel Hy Important: if Item 27 is marked oth any Injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest B. Raughley Eva Elizabeth Stafford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald A. Roberts/son 9110 Lennings Lane, Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/26/00 Frederica, DE Barratts Chapel Cemetery Parsell Funeral Homes & Crematory, Inc. 1449 Kings Highway, Lewes, DE 19958 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, that only one cause on each line. 23a. Part1. Enter the d shock, or heart fa Approximate Interval Between Onset and Death Physician ATHEROJECTROTIC CARDIOVASCUCAR DIS Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner ettending physician and for use as the burlel-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ate has been signed to page 2 should be det Records. ģ 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? MAZ PATLUNE r this certificate h 1 Yes ANO 2ENO 1 Yes Division of Vital e Hospital or Attending Physicien: 24 hours efter death.
9 Funeral Director: After this certifica etely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: Medical Certification: To 1 Yes Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Hatural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated to the cause (s) and menner as stated to the cause (s) and menner as stated to the cause (s) and due to th To the Hosp within 24 hor To the Fune completely fi ner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) MU 30. Name and address of pe rson who completed cause of death (Item 23a) (Type, Print) 38 MOEN 31. Date filed (Month, Day, Year) MAY 2 5 2000 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 19392

	Decedent's Name (First, Middle	(ast)		Ooranoat	e of l	Jean	2. Data of Deat	ng. No.		3. Tima of Death
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/Medical	4a Facility Name (If not institution, give street and number)				4b. City, Town			4c. County	of Death	1820
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Funeral			(In yrs. last birti		r 1 Year				9. Birthp	laca (Stata or Foreign
Director	221-03-4685 Usual Residence of Decedent	12 M 2□ F	90	rs. Months	Days	Hours Min.	8. Date of Birth (Month, Day June 19,	1909 F	otts	town, PA
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or 28a-1 show be notified at Director	10e. Street and Number			10f. Zig	Code		1	Og. Citizen of W	/hat Coun	itry?
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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Doris Mae Sexton 8:10 pm 2000 June 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Jones Acres Arnold Anne Arundel | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) | Oct 4, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2⊠ F 88 212-22-9939 Yrs. 1911 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1349 Jones Station Road 21012 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dales: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Stalus 1 Never Merried 2 Married 1 Yes 2℃ No Specify: White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John Colburn Elizabeth Collins 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Sexton 628 Kensington Avenue, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other piece 20a. Method of Disposition Date 20c. Location - City or Town, State June 5 2000 1 Burial 2 Cremation 3 Removal from State Elkridge, MD Meadowridge Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Si 22. Name and Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home Gov. Ritchie Hwy., Severna Park, MD 21146 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, show or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deall Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy

Physician/Medical Examiner attending physician and for use as the buriel-transit

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

**Funeral** 

Director

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**Physician** 

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To the Hospital or Atlanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I

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Certification: To

Medical

Box 68760.

P.O. I

Division of Vitai Records,

/Medical Examiner

Baitimore, Maryland 21215-0020

25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28l. Location (Street end Number or Rurel Route Number, City or Town, Stele) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie

29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) JUNE 02, 2000

199 COUSE (1907) 230 ATYPORE INTITCHLE HIGHWAY, BALTIMORE, AND -21

State Registrar 31. Date liled (Month, Day, Year)

JUN 0 6 2000

32. Registrar's Signature

MD

**DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 **Physician** 02 RODNEY PAUL SMITH 2000 0055 /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day Year) 5. Social Security Number 6. Sex 1 → M 2 □ F 9. Birthplace (State or Foreign **Funeral** Months Days Hours Washington, DC Yrs 218 76 4498 Director Uauel Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show Nem 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified as MD Anne Arundel Annapolis 1 Yes 2 No **Funeral Director** 10a. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1751 B and A Boulevard 21401 USA death . Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or has any injury or other trainment. Never Married 2 Married Baltimore, Maryland 21215-0020 White 1 Yes 20 No Specify: Be Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 18. Mother's Nama (First, Middla, Maiden Sumame) 17. Father's Name (First, Middla, Last) Dorothy L. Smith Rodney C. Smith 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Rodney Smith (father) 1751 B & A Blvd., Annapolis MD 21401 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St Anne's Cemetery 6/3/00 Annapolis MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Advent Funeral & Cremation Services oner Annapolis MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Examiner (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last and Due to (or as a consequence of): Box 68760, physician Physician/Medicai Due to (or as a consequence of) signed by the attending p Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by phous 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to complation of causa of death? page 2 s hes 1 🗆 Yas 211110 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was casa refarred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No edicai Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of tnjury (Month, Day Year) funerei 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Panding investigation 1 Yas 2 No within 24 hours after death. To the Funeral Director: A the 1 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide ro the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manger stated. 29a. Certifier completely (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature 30. Neme and address of person 0 31. Date filed (Month, Day, Year) 32. Registrer's Signature State agreen Registrar

### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9395 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Year **Physician** Smit Mary Elizabeth 4:15 PM June 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Genesis ElderCare The Pines Easton Talbot If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 219-44-1759 10 M 20 F Deys Yrs. Director Sept.16 Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 1 Yes 2 No Director albot 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 216 P.O. BOX Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indien, Black, White, etc. 11. Meritel Stetus 1 ☐ Navar Married 2 ☐ Merried Smith Maryland 21215-0020 1□ Yes 2□ No 'natural', or Specify: 3 Widowed 4 □ Divorced Black 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 0 omestic PR: vate Work 17. Fether's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Be merked Unknown unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) P.O. BOX 281 important: If Item 27 any injury or other to Willie Trappe Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 Cremetion 3 Removel from Stete 6/8/2000 Trappe, Paradise 4 ☐ Donetion 5 ☐ Other (Specify) Cemeters 21. Signature of Funerel Service Licenses 22. Nama and Address of Facility Henry Funera 510 Washington Home Funeral St. Campridge, MD. 21613 23a. Part1. Enter the diseasa, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart tailure. List only one cause on each line. **Physician** Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner 18813 Physician/Medical Examiner weti-interest Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the bune P.O. Box 68760, Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records. Be Completed by 24b. Were eutopsy tindings eveilable prior to completion of cause of death? 24e. Wes en autopsy performed? antern 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) end menner stated. edical 29e, Certifier (Check only 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) ROWLLY 508 MICHARL TALEWILD MD

State Registrar 31. Date filed (Month, Day, Year)

JUN 0 6 2000

DHMH 16 Rev 6/95

32. Registrar's Signeture

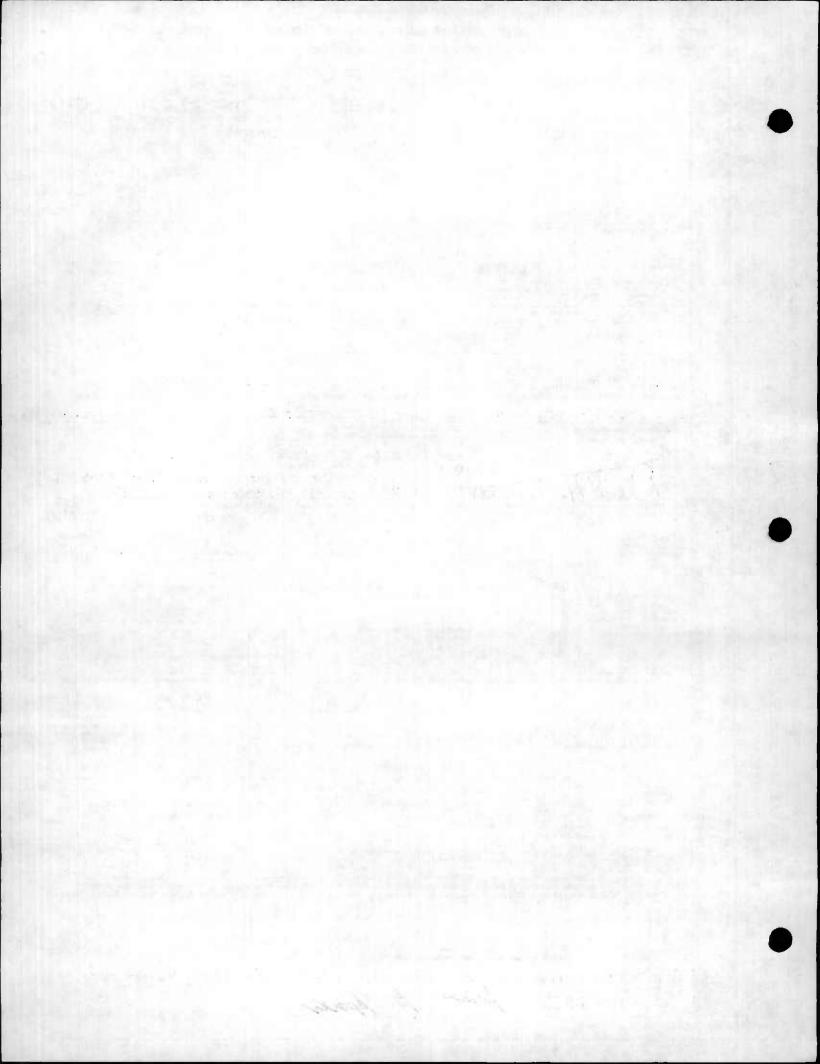
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# Peggy Stout SS#225-52-9904 Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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smit. Pag epartment sportant: I sy injury o	21. Signature of Funaruj Service Lice	ensee Mc	1051		Name and Ad		У						
20158	David &	homoro							y, MD 2]		sociation		
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Physician	shock, or heert failure. List only	y one cause on each i	ine.	777	70	I Justin				1	Interval Between Onset and Death		
/Medical	immediate Cause (Final disease or condition			4	+SCV	0				1	1		
Examiner	resulting in death)	a	Due to (or as a		•					1			
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iteste be executed physician and is the burist-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury												
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d by d by Phy									1 Yes 2 No 3 Probably 4 Unkn				
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stclen: The law requires that the death cer certificate has been signed by the attendin lirector, page 2 should be detached for use be Completed by Physiclan/N								10	Yes 2 No	10	☐ Yes 2000		
entifica ector, Be C	25. Was case referred to medical examiner?					26. Place	of Deal	th (Check only	one)				
Se se	1 No 2 No									er (Specif	y)		
her ther the mena	27. Manner of Death  1 2 Natural 5 Pending	28a. Date of Inju (Month, Da	ny Year) 28b.	Time of Injury		jury at Vork?		28d. Describe	how injury occur	red			
tend fleath flor: / the f	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							00/ 1	0		10.11		
or At after of in by								28f. Location (Street end Number or Rural Route Number, City or Town, State)					
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the thin 2 the mple	20h Signatura and title of construct	and manner st	eted.		20a Lin	ense number			29d. Date signe	d /Alanth	New Year)		
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Ale	w ar				1	3049	1		21/12/15	00 .			
boll	30. Name and address of person who DV. C ハッシ S ハ 31. Date filed (Month, Day, Year)	completed cause of o	death (Item 23a)	(Type, f	Print)		-	-15 1		215			
	31. Date filed (Month, Day, Year)	y over 1	of Miles	CHD.	57, J W	201	, 30	10 95' m	ry md	480	4		
State Registrar	MBY 3 A 7	000	ar a Signature	19.	Lon	1/1							
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month ANDREW JOSEPH 8:34 P.M. SCHULTZ SR. 21, 2000 MAY 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BERLIN NURSING & REHABILITATION CENTER BERLIN
If Under 24 Hrs. WORCESTER ff Under 1 Year 6. Sex 1X M 2□ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Yrs 105-14-7005 JULY 8, 1917 PENNSYLVANIA Usual Residenca of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2000 Director MARYLAND WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9847 TIMMONSTOWN ROAD 21811 IISA 12. Was Decedent Evar in U,S. Armed Forces? 1 ∰Yes 2 □ No it Yes, Give Year or Dates: 1941–45 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 N Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 HEAVY EQUIPMENT OPERATOR CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) a JOHN SCHULTZ MARY SVITANA 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 9847 TIMMONSTOWN ROAD, BERLIN, MARYLAND 21811 N. JEAN SCHULTZ/WIFE 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OAKHALL RIVERSIDE CEM. 5/24/00 BERLIN, MARYLAND 22. Nama and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 23a. Part1. Enter the disease, or complications that caused the official. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician/Medical Examiner phno (nteniol Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disaase or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): minsulin Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Doknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an eutopsy 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Naturat 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signatura and title of cerafin 29c. License number 29d. Date signed (Month, Day, Year) 22 D02026 30. Name and address of person who completed cause of death (Jem 23a) (Type, Print) 46 TEAL CIRCLE, BERLIN, MD. DR. FEDERICO ARTHES, MD 410-641-4400

State Registrar

DHMH 16 Rev 6/95

Programme Someture

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**Physician** 

/Medical Examiner

**Funeral** Director

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Saltimore, Maryland 21215-0020 and 2 should be saith and Mental poemit. Pages 1 and 2 a. Department of Health and Important if Item 27 is ma any Injury or other to RDSs.

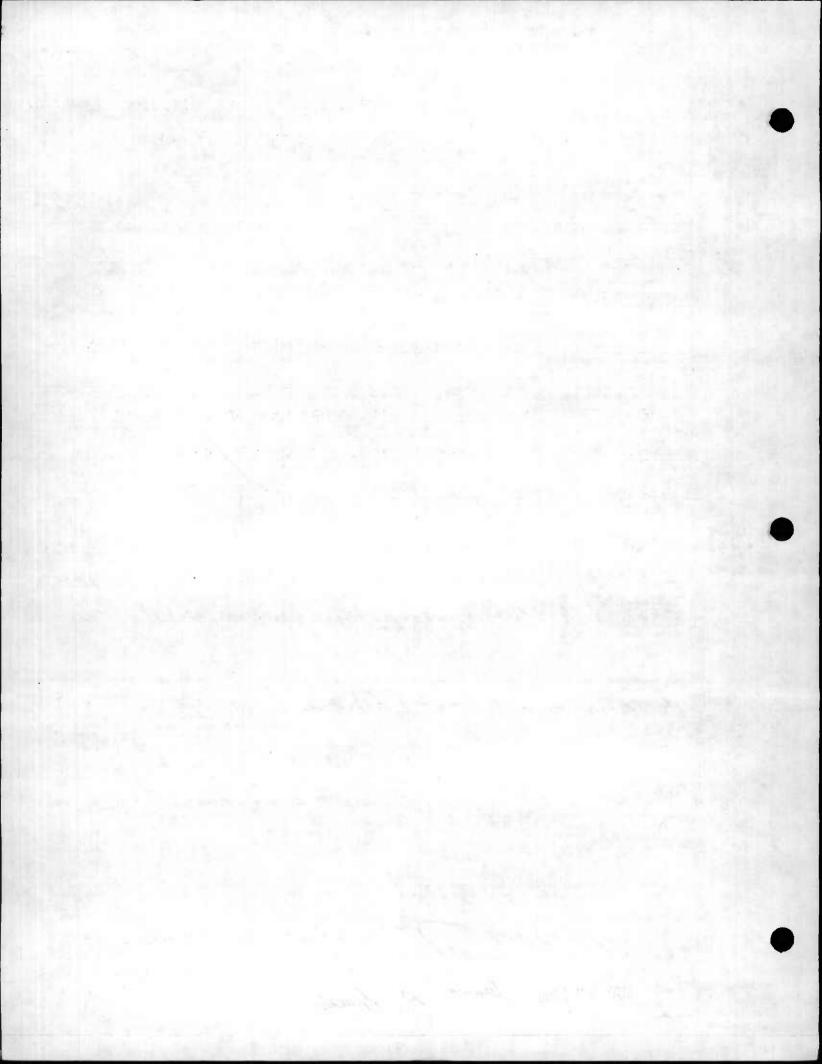
SCHULTZ, ANDREW

**Physician** /Medical Examiner

attending physician and for use as the burial-transit Box 68760. The law requires that the death certificate be signed by t certificate To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p.

P.O. Records, of Vital Division



### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death SMITH Month **Physician** Yaai BASIL 16 4b. City, Town, or Location of Death 10 AM 23 70 2000 /Medical 4e. Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner CARE System VA MARYLAND HEAlth Ambridge Dorchester If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Oct. 22 15 7. Aga (In yrs. last birthday) If Under 1 Year Months Days 5. Sociel Sacurity Number 6. Sax **Funeral** Birthpieca (Stata or Foraign Country) 1 M 2 F 215-05-9906 Days 80 1919 Maryland Director Usual Rasidence of Decedant Smit death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location permit. Pagas 1 and 2 should be filed within 72 hours after death with tha Maryian Department of Haelth and Mental Hygiena. Important: If them 27 is marked other than "netural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner made to nothing a 10d. inside City Limits 1 Yas 2 No Director Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 305 Newton Street 21801 U.S.A 12. Was Dacedant Evar in U,S. Armed Forces? 1 Byas 2 □ No IrYas, Giva Yaar or Datas: WW 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Physician Biack, Whita, atc 1 ☐ Navar Married 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No þ Specify: 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Bualness/Industry Elamantery/Secondary (0-12) Collega (1-4or 5+) 12 None Laborer Know to 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surneme) Upshur Smith Lillian Waters 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) 305 Newton Street Salisbury, Md. 21801 Mary Ann Smith (Daughter) 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) 30/00 Hurlock, Md. Vet.Cem.Eastern Shore 22. Nama and Addrass of Facility Stewart Funeral 21. Signatura of Funarai Sarvice Licansee Home 821 West Rd.Salisbury, Md.21801 23m Part T. Entar tha disease, or complications that caused the desired shock, or heart failure. List only one cause on each line. To not enter the mode of dying, such es cardiec or raspiratory arrest, Approximata intarval Between Onsat and Death **Physician** Ittour immediata Causa (Final disaasa or condition resulting in daath) /Medical · Cardio-pulmonary 36 m **Examiner** Dua to (or as a consequence of): Colonoly Vacture. Due to (or as a consequence of): disease ettanding physician and for usa as the burial-transit Exami Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Diseasa or Injury P.O. Box 68760. Due to (or es e consequence of): Physician/Medical that initieted avents resulting in death) Last multiple strokes cheval Vaseula disease deft 23b. old Peripheral BKA. signed by the e Part ii. Other significant conditions contributing to death but not rasulting in the undarlying causa given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Records, by 24b. Ware eutopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? certificata has 1 ☐ Yes 2 1 No 1 □ Yes 2 □ No Division of Vital 25. Was casa rafarred to medical examples? Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 10 1 Yas 2 No this tha funaral 27. Manper of Death 28a. Date of injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th complately filled in by the funera 28b. Tima of 28d. Describe how injury occurred Certification: Affar 5 Panding invastigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accidant 8 Could not be determined 3 ☐ Suicide 28a. Place of injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Phyaician: To tha best of my knowledge, death occurred at tha tima, date and piace, and dua to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and piace, and dua to the cause(a) and mannar stated. 29a. Certifian 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Dav. Year) May 23 rd, 2000 D30528 30. Nama and addrass of person who complated cause of death (item 23a) (Type, Print)

VA out ft dinie, CAMBRIDGE, MD 21613

S. DUGGIRALA M.D.

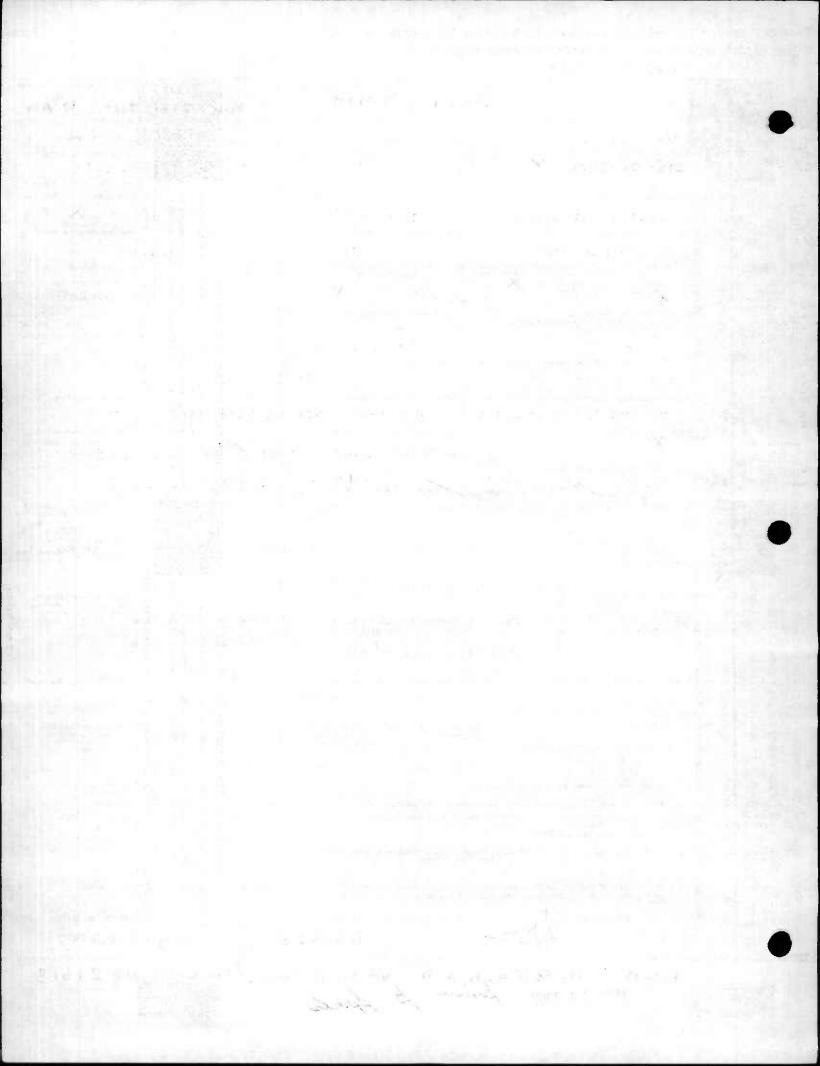
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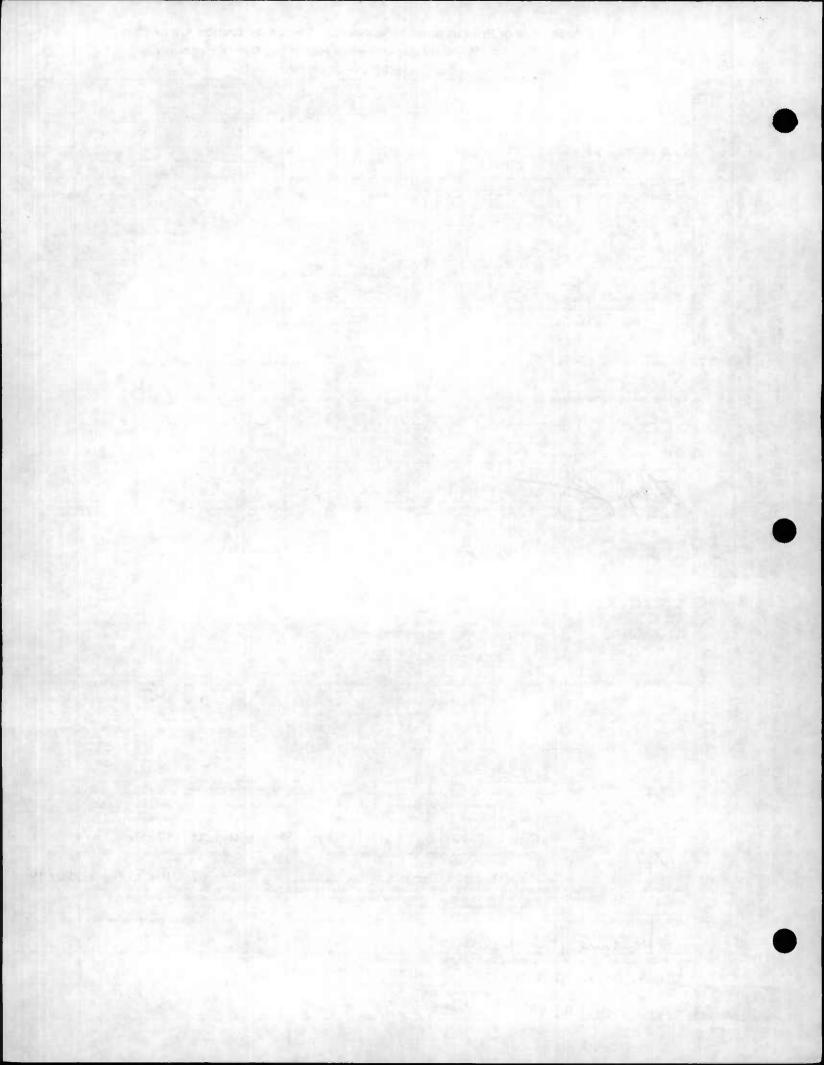
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State of Man	yland / Department of Health and	Mental Hygiene	9399
TAMMY D. THOMPSON	Certificate of Death	Reg. No.	2022
nt's Name (First, Middle, Last)		2. Date of Death	3. Tima of Death
my D. Thompson		JUNE 5, 2000	0217 A

Division of Vital Records, P.O. Box 68760.

Physicia		Tammy D. Th	ompson						Month JUNE	5, 200	Year	0217 AM
/Medica Examine	_	4a Facility Nama (If not institution	n, give street and					4b. City, Town, or		th 4c. County	ot Death	
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Funeral	5. Social Security Number 6. Sec		n yrs. last birthday	If Under 1 Year		8. Dete of Birt (Month, De		Birthplace (State or Foreign Country)
Director	217-16-9275	M 2 F	7.7 Yrs.	Months Days	Hours Min.	Dec. 8	y, Year) 1922 M	Country) laryland
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he N	Maryland Talbot		Easton	401 7in Onda			40- 00	
Aith No.	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
23 Peth	103 Hammond Str		visus Las	21601		- W - W N -	USA	American traffer
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end M	19a. Informant's Neme/Reletionship (Ty		19b. Maili	na Address (Street	t and Number or Rui			teta, Zip Code)
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Department of Health mportant: If item 27 any injury or other tr ance.	4 Donetion 5 Other (Specify)		Maryland			/22/2000	Hurloc	k,Maryland
any i	21. Signature of Funerel Service Licens	7	2	2. Name and Addre Bennie Si	mith Fune	ral Home	2	
		-		P.O.Box	1687, Eas	ton, Mary	land 216	501
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ge 2								
or, page						101		1 Yes 2 No
m gg	25. Wes case referred to medical examiner?	lospitel:		Ott Doc Ott	26. Place of Deal		_	Thiraid
Pie P	TES ZEPNO	1 L Inpatient	2 ER/Outpatie	nt 3LI DOA	4 LI Nursing H		lence 8 DOther	1.100
After funer lon:	27. Menner of Deeth  1 Netural 5 Pending	28e. Dete of Injury (Month, Day Ye	par) 28b. Time o	Wo		28d. Describe h	now injury occurred	4008
by the f	2 Accident invastigation 3 Suicide 6 Could not be				Yes 2 □ No	not to at a	N	- 0 - 10 - 1 - 1
	4 Homicide determined	28e. Plece of Injury building, etc. (5	- At homa, farm, st Specify)	reet, factory, office		28f. Location (S City or Tox	otreet and Number vn, Stete)	or Rurel Route Number,
	29a. Certifier 1 Certifying Phys	ofclan: To the best of m	v knowledne deet	h occurred at the ti	me date end place	end due to the	causa(s) and mann	ner es stated
plately fill edical	(Check only 2 Medical Examir	ner: On the basis of exa	aminetion and/or In	vestigation, in my	opinion, deeth occur	red et the time,	dete end plece, en	d due to the cause(s)
Me Me	290. Signature and 1996 of fertifier			29c. Licens	se number		29d. Date signed (	(Month, Dey, Year)
; <b>⊢</b> 6	> /// W/L	1		100	21011		5-10	7.00
	The state of the s			125	21719		5-1	1-00
	30. Name and address of person with co	mpleted cause of death	h (Item 23a) (Type,	Print)	DUTCH	A. A. S. A. S.	1 1	ASTON, MD
	LUR. KATHRYY	V MELSA	+KECK	,001	DUTCH	MANS	LIV. C	ASTON, IND

State Registrar

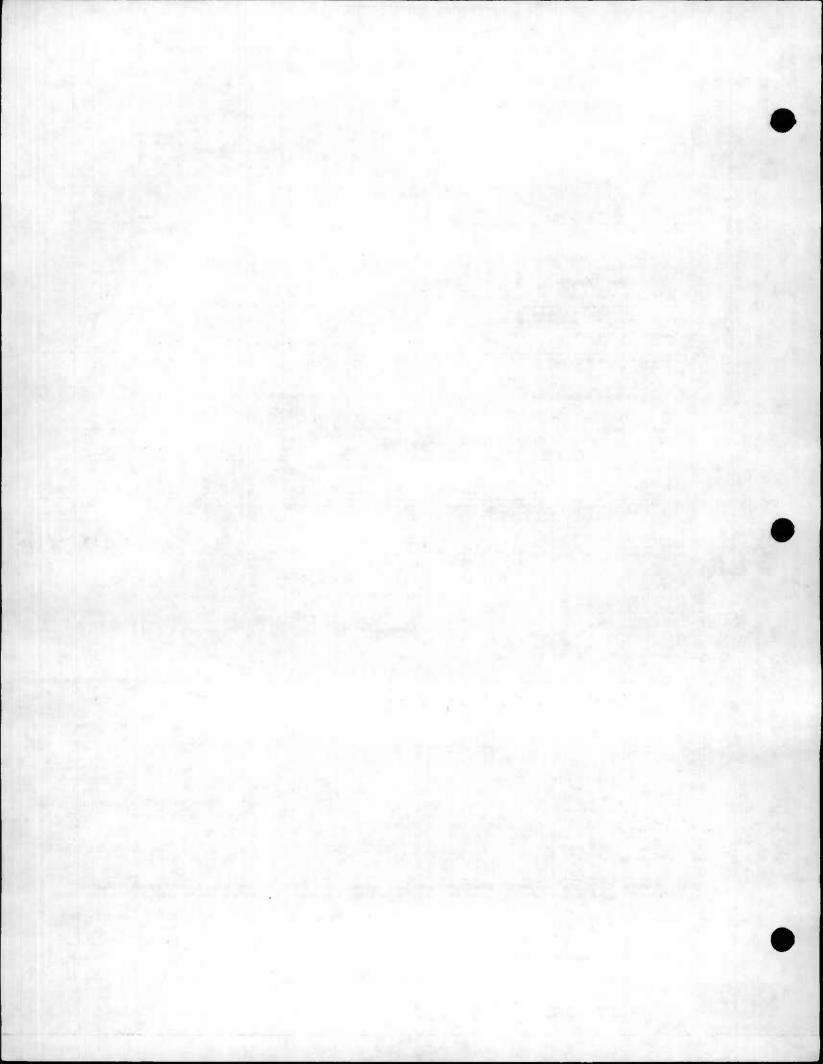
31. Date filed (Month, Dey, Year)

MAY 2 2 2000

DHMH 16 Rev 6/95

**ORIGINAL** 

32. Registrer's Signeture



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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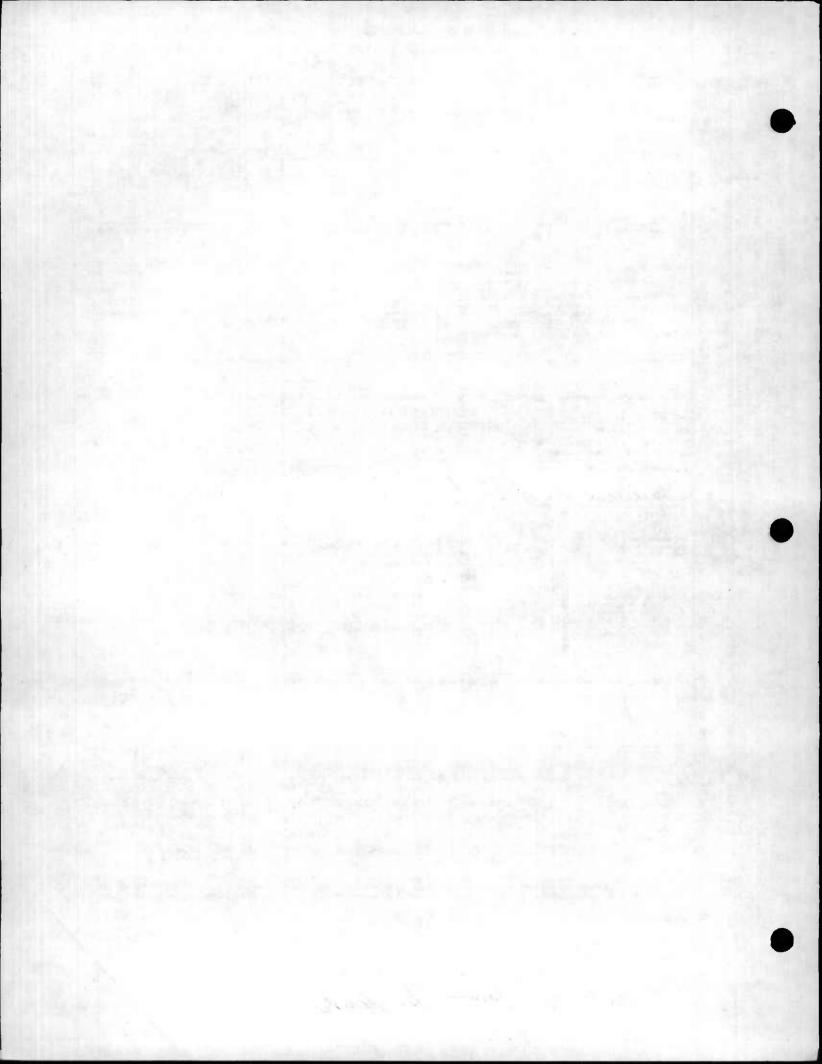
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sician	TITE A									Month	Day	Year	1005
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miner	4a Facility Name	(If not institution, gi	ve street and nu	um <i>ber)</i>				4b. City, 10	own, or Lo	cation of Deat	4c. Coun	ty of Death	
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	10a. State	10b. County		10c. C	ity, Town or Le	ocation						1	Od. toside City Lin
7		-											1 ☐ Yes 2 🖔
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Director	10e. Street and Nu	umber				10f. Ziş	p Code				10g. Citizen of	What Cour	ntry?
-	14 DOW	NING ST.					216	01			US	Δ.	
Funeral	11. Marital Status	MINO DI	12. Was Dec	cedent Ever in I	U.S. 13.	Was Dece			igin? (Spe	ecity Yes or No		ce - Americ	can Indian,
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BeC													
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Vera May Thomas

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9402 Certificate of Death amend item 20b per fh G785 7/13/00 yg 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 19 Physician Myra W. Taylor May 2000 6:10 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico Waterview Health Care If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 21 F Yrs. 221-07-4651 Director March 5, 1916 Delaware **Usual Residence of Decedent** 10n State 10b. County 10c. City. Town or Location 10d. Inside City Limits DE Sussex Laurel 1 Yes 2 No Director or 28a-f p 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herna 23a 19956 USA 511 Pine Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Id be filed within 72 hours after des lental Hyglene. Ked other than "natural", or hema Ic event, the Medical Examiner m 1 ☐ Never Married 2 ₹ Married 1 ☐ Yes 2 ☑ No 21215-0020 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dentist office Dental Assistant Saltimore, Maryland parmii. Pages 1 and 2 should be tile Department of Health and Mental Hy Important: If Nem 27 le marked othe any Injury or other treumatic event pices. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 89 Horace L. Bailey Anna Luphold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Pine Street Laurel, DE 19956 Monroe Taylor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 5-23-00 Laurel, DE Odd Fellows Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Short Funeral Home 700 West Street Laurel, DE 19956 702 M. 23a. Part1. Enter the disease, or complications that caused his death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each rine. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Mchustaha lung concer Examiner Due to (or as a consequence of). Physician/Medical Examiner HM The law requires that the death certificate be executed ettending physician and for use as the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, crohms Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? cate has been signed by page 2 should be detect 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to Be Completed 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No certificate of Vitai Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 28a. Date of Injury (Month, Day Year) Division 1 (Natural 5 Pending investigation or Attendinefre destr. 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide 5 To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

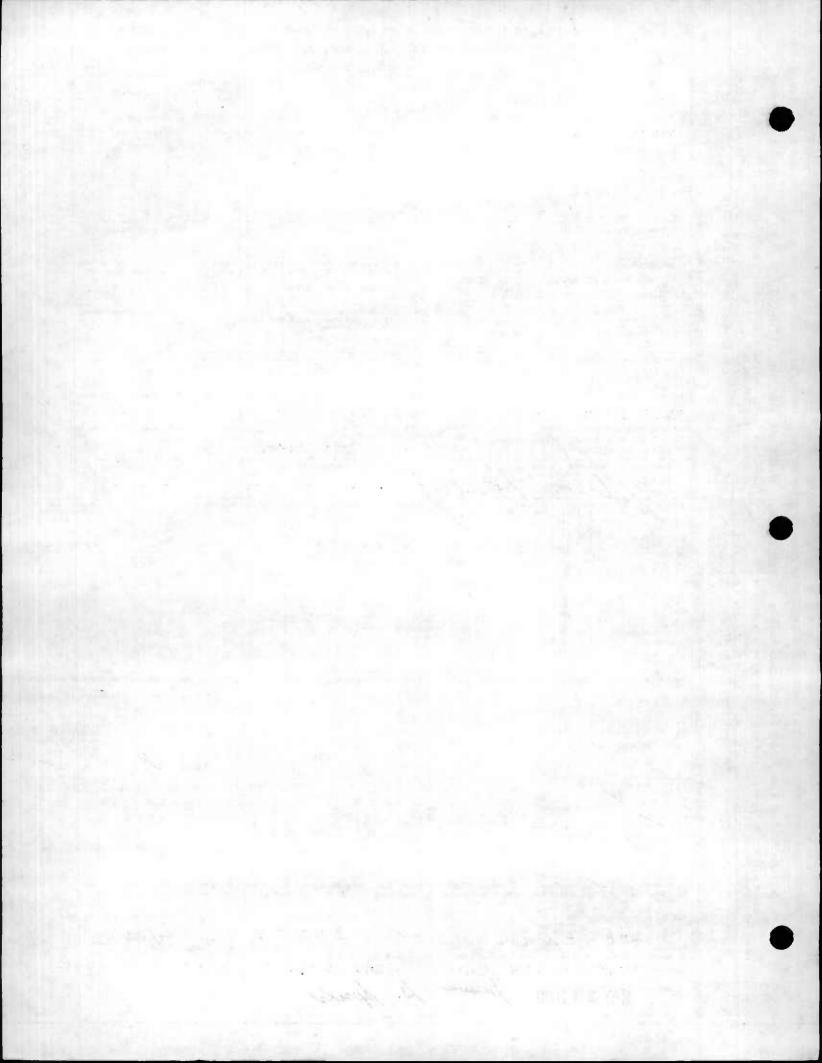
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 847094 5/22/00 Natguar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATESAN STREET 21801 106 MILFORD SALI SBURY MD 31. Date filed (Month, Day, Year) MAY 2 3 2000 32. Registrar's Signature State Registrar



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Tima of Death Year Month **Physician** T.OT.A B THOMPSON MAY 20 2000 8:00 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1313 WESTCHESTER ST. SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sax 7. Age (In yrs. last birthday) **Funeral** 1□M 2K) F Yrs. 83 Director 214-10-7105 SEPT. 29 1916 DELAWARE Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow 14 Yes 2 □ No Director MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ò 1313 WESTCHESTER ST 21801 'natural', or home 23a U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Merried 2 Merried Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Detes WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department or Health and Mental Hygian, Important: if them 27 Is marked other that any Injury or other traumatic event, the 100s. SEAMSTRESS SHIRT FACTORY 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM 0. ROBINSON MINNIE CAREY M. 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAMUEL THOMPSON - HUSBAND 1313 WESTCHESTER ST. SALISBURY, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State SPRINGHILL MEMORY GARDENS 5/24/00 HEBRON, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 705 E. MAIN ST. 21. Signature of Funerel Service Licensee 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 23a. Pert Enler the disease, or complications that caused the disease, or heert feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical ALZHEIMER'S YEARS **Examiner** Due to (or as a consequence of): Physician/Medical Examiner physician and s the burial-transit the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760 thet initiated events resulting in deeth) Lest Due to (or es a consequence of): attending for usa as usa as P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy paga 2 s 1 Yes 2 No 1 ☐ Yes 2 No certificata Vital al or Attending Physician: The safter death.

If Director: After this certificated in by the funeral director, pages. 89 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 Yes 2 No Certification: To Division of 27. Manner of Death 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Panding 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled. Medical 29e. Certifier (Check only one) 29c. License number 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERRER NO 8 BAST GROVE ST. DELMAR, DE 19940 31. Dete filed (Marth, Pay Year) 2000 32. Projetra Signature State Registrar



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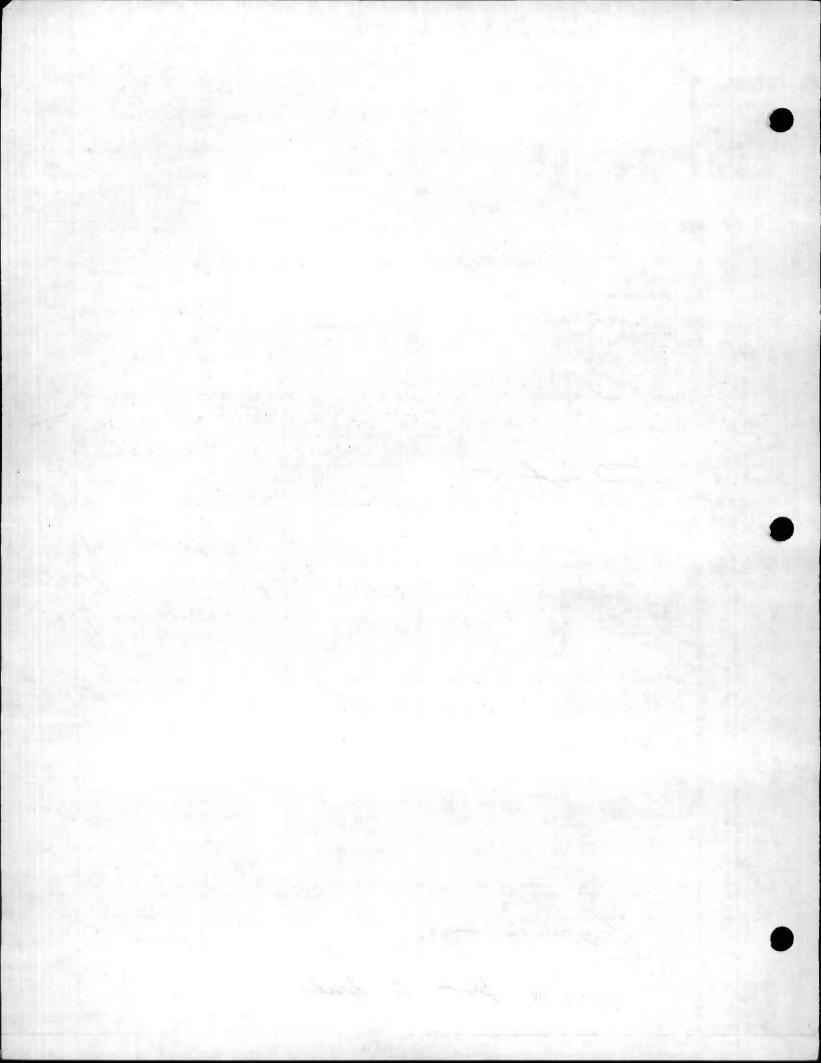
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Walter Tunnell MAY 20 2000 6:00AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing & Rehabilitation Center Berlin Worcester 8. Date of Birth Month, Day, Year) June 16, 1916 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country)
 DE **Funeral** 11⊠ M 2□ F 222-01-9452 83 YES **Director** Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ty Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 312 Wolf Terrance, Apt. 10 'natural', or Items 23s 21811 U.S. 12. Was Decedent Ever in U,S. Armed Forces? 1-1 Yes 2 □ No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2X No Specify: Black 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) laborer 6th various and Mental Hygi is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 and 2 should be Lyle Tunnell Elsie Johnson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is m Bertha Milbourne/daughter P. O. Box 253, Showell, MD 21862 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Curtis UMC Cemetery 5/26/2000 Bishopville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 Approximate Interval Between Onset and Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** Immediete Cause (Final diseese or condition resulting in deeth) /Medical te alyocandin/infinct Examiner Examiner ntery Disinse Tear Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Mellitus- Insolin Rip. 765attending physician Box 68760. The law requires that the death certificate be Physician/Medical P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to Be Completed 24a. Wes an autopsy completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 No certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Wes case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 Neturel 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier 29b. Signeture and titled certifier 29c. License number 29d. Date signed (Month, Day, Year) D02026 nur 21-2000 30. Name and address of person who completed cause of dual. (Item 23a) (Type, Print) 46 TEAL CIRCLE, DR. FEDERICO ARTHES, MD BERLIN, MD. 21811 410-641-4400

State

31. Dete filed (Month, Dey, Year) MAY 2 6 2000

32. Regress Christure



# ED WARD L. TAYLOR 220-28-1273

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Physician 2000° 1624 Blanche Chiswell Wootton June 1 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Kent The Kent and Queen Anne's Hospital, Inc. Chestertown 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) Sept . 27, 1911 6 Sex **Funeral** Months Days 1 M 2 F Yrs. Director 214-03-8037 88 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No Directo Rock Hall Maryland Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 'natural', or itsms 23a 3944 Eastern Neck Road. 21661 USA Funera 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married Saitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 4 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Bowling Professional Sports/Bowling permit. Pages 1 and 2 should be III. Caparitment of Health and Mental Hy important. If New 27 is merited other any injury or other traument. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Edith Chiswell Norman Wootton 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 28 High Ridge Road Leicester, N.C. 28748 Norman Joseph Wootton 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from Stete 4 Donetion 5 Other (Specify) Chesapeake Cremation Cntr 6/4 Stevensville, MD. 21. Signeture of Funeral Service Licansee 22. Name and Address of Facility
Fellows, Helfenbein, Newnam Funeral Home PA 130 SPeer Rd. Chestertown, Md. 21620 plications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, 23a. Pert1. Enter the disease, or shock, or heart tellure. List Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical 30475 ACUTE GIBLETOS Examiner Physician/Medical Examiner NURT IMMA CONOMINA 12 Heens attending physician and for use as the burial-transit cartificata be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): Box 68760. Due to (or as e consequence of) P.O. 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 25 No 3 Probably 4 Unknown signed b Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en eutopsy page 2 1 Yes 2. No 1 ☐ Yes 2 ☐ No cartificate Division of Vital Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No edical Certification: To this 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Aftar Hospital or Attending 5 Pending investigation 1 Netural 1 Yes 2 No daeth. 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) after 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 15 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 17-13824 6-1-00 MM ren 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) John C. Seymour, 122 Speer Road, Suite 5, Chestertown, Maryland 21620

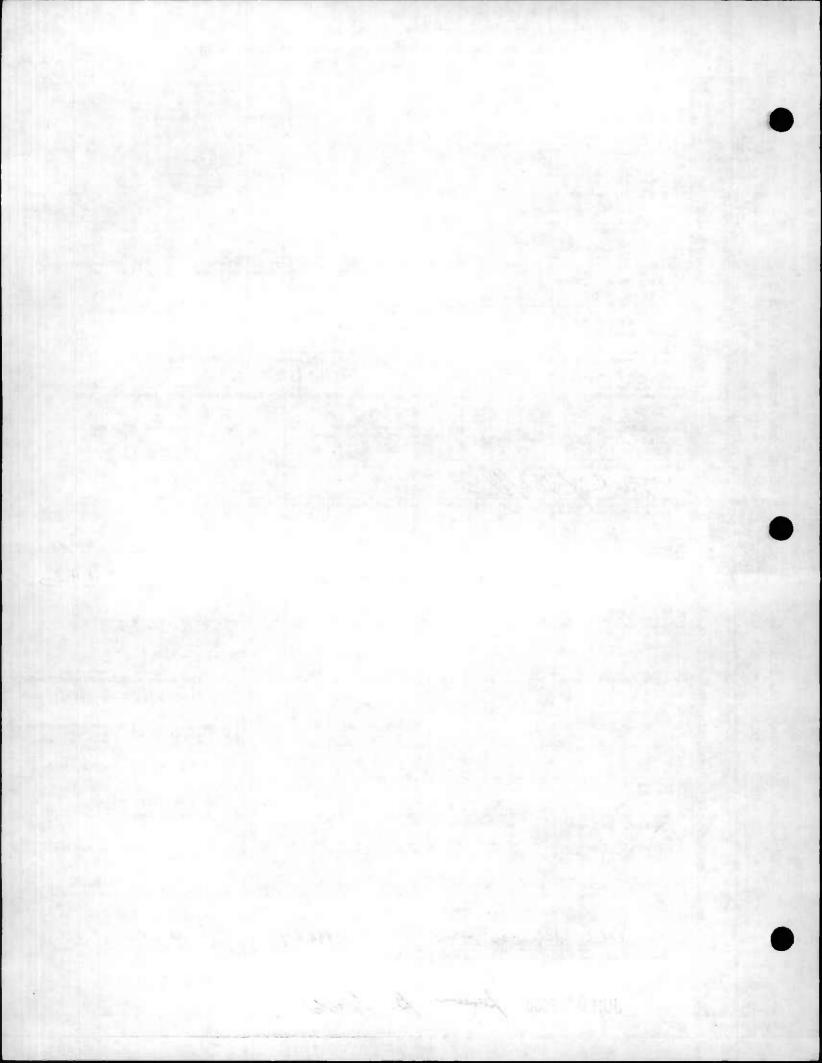
Registrar **DHMH 16 Rev 6/95** 

State

31. Dete filed (Month, Dey, Year)

JUN 0 5 2000

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 13 70 **Physician** WICKES JONES FAN ELIZABETH (0) /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death HomE Examiner LAGNOLIA HALL NURSING & CONVALESCENT HESTERTOWN KENT 7. Age (In yrs. lest birthdey) If Under 1 Yeer Months Deys if Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 03 20 2 6. Sex Birthplece (State or Foreign Country) **Funeral** Hours 1 M 2 P 72 Yrs. 213-22-9742 Director Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Example: must be notified at 1 Tes 2 No HESTERTOWN KENT Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21620 USA permit. Pages 1 and 2 should be filled within 72 hours after death 10 begartness of Heath and Mental Hygison. Important if fleam 27 is merked other than "netural", or fleam 23 any injury or other transmits event, the Medical Examinational mast Funeral . Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 12. Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Saltimore, Maryland 21215-0020 Specify: þ 3 ₩idowed 4 Divorced DLACK Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) ARE GIVER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) HENRIETTA LKOUN ONES 19a. tnforment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2/620 KD APT 51 · CHESTER TOWN MO LAND FLAT WICKES 20b. Pieca of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Pete 20c. Location - City or Town, Stete ■ Pauriei 2 Cremetion 3 Removei from Stete 20 CHESTER TOWN MO 4 ☐ Donetion 5 ☐ Other (Specify) MMANUEL U.M. CEM. 100 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility CHESTERTONN MO TUNERAL HOME. Enter the disease, or complications that caused the dear Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Ceremovascular Accident immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequenca of): Examiner 4 pendension The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest ettending physician and for use as the buriel-tran Due to (or es e consequenca of): 1ab Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of) signed by the eld be detached for Pert ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown tan þ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy Completed peeu this certificate has ral director, page 2 2 No 1 ☐ Yes 2 No 1 Yes or Attending Physician: Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Manner of Deeth 28e. Dete of injury (Month, Dey Year) 28c. injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Neturei 5 Pending injury death. investigation 1 Yes 2 Accident ofter death Director: A d in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours eft To the Funeral Di-completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end manner es stated.
2 Medical Examtner: On the best of examination end/or Investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated. 29e. Certifier Medical (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number MD 00 18 30. Name end address of person who completed cause of deeth (item 23e) (Type, Print) HNDREW FERCUSON. 120 SPEER KO. CHESTERTOWN Dey, Year 8 32. Registrar's Signeture 31. Dete filed (Month, State 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Daath 3. Time of Death Month **Physician** GUSTOVA EMILE Y'PINA May 22 2000 04:48 /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Easton, Memorial Hospital @ Easton MD Talbot 6. Sax 1 → 2 □ F If Undar 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplaca (S Sept. 28,1922 Georgia 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Deys Months Hours Director 096-14-4121 Usual Rasidance of Dacedant death with the Marylend 10b. County 10c. City, Town or Location 10d. fnsida City Limits d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at 1 Tas 2 No Director Maryland Talbot St. Michaels 10e, Street and Numbar 10g. Citizan of What Country? 10f. Zip Coda 24862 Swan Rd. U.S.A. 21663 Funeral 12. Was Dacedant Evar in U,S.
Armed Forcas?
1 Dives 2 No WWII If Yas, Siva Yaar or Datas Coast Guard Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Reca - Amarican Indian, Black, Whita, atc. 11. Marital Status Pages 1 end 2 should be filed within 72 hours efter nent of Health end Mental Hygiene. 1 Nevar Married 2 Married Gustavo, E. Ypina Baltimore, Maryland 21215-0020 White Specify: by "natural", 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Teamster Trucking item 27 is marked other other traumatic event, is 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Malden Surnama) Be Veronica A. Amonetti Gustova R, Y'Pina 2 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zlp Coda) 2341 Rosedown Dr. Reston, Virginia James B. Shellem Son in law 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Steta Department of important: If it any injury or o 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Capitol Crematory May22, 2000 Dover, Delaware 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Harrison E. Leonard Funeral Home 312 S. Talbot St St. Michaels, Maryland 21663 Zua. Part1. Entar tha disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one clusa on each line. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Finai disaasa or condition rasulting in daath) /Medical Intra abdominal sepsis 16 hrs. Examiner Dua to (or as a consequanca of): Examiner Perforated Sigmoid Cancer ed by the ettending physician and detached for use es the bunel-transit The law requires that the death certificate be executed Sequantielly list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury thal initiated avants resulting In daath) Last Dua to (or es a consequança of): Hepatic Metastasis Physician/Medicai Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown S/P CVA signed i ð should Completed 24a. Was an autopsy performed? Ware eutopsy findings available prior to complation of cause of death? page 2 1 Yas 2 No certificate 1 Yas 2 No 25. Was casa rafarred to medical examiner? Be 28. Piaca of Daath (Chack only ona) 1 Yas 2 No Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 10 this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident

P.O. Records, Division of Vital

or Attending Physician: Affer n 24 hours after death.

• Funeral Director: Aft bletely filled in by the fur Hospital To the Hosp within 24 ho To the Fune completely fi

> State Registrar

Stanley Bysshe 31. Date filed (Month, Day, Yaar)

MAY 2 3 2000

6 Could not be determined

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3 Suicida

29a, Cartifian

4 Homicida

(Check only one)

29b. Signatura and titla of certifian

30. Name and addrass of parson who complated causa of death (Itam 23e) (Type, Print) M.D. 505 Dutchmans Lane Easton, Maryland 21601 32. Registrar's Signatura

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28a. Place of Injury - At homa, ferm, streat, factory, office building, atc. (Specify)

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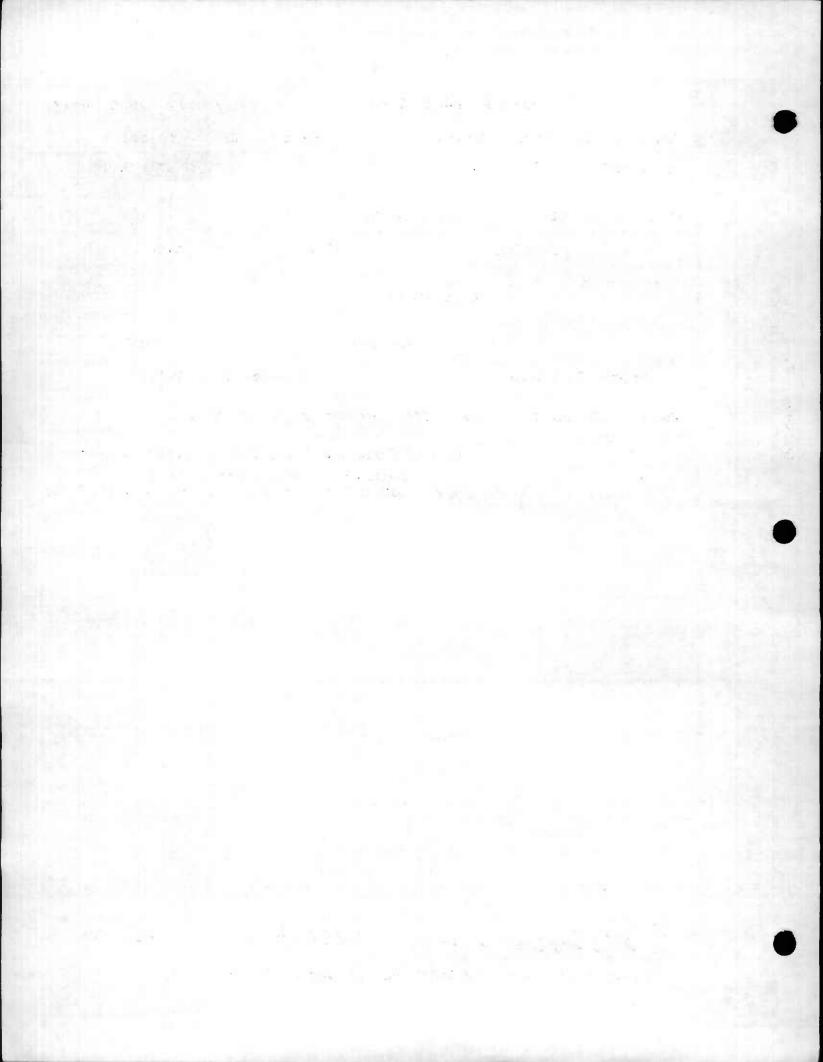
1 Nertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as staled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. Licansa number

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29d. Data signad (Month, Day, Year)

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## State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month **Physician** 7:55PM Ivester 03 Woodrow -2000 Du /Medical 4c. County of Deeth 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Baltimore Nemori OSP a a 8. Date of Birth (Month, Dey, Year) nion If Under 1 Yeer 9. Birthplece (State or Foreign Country) If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 10M 20F Months 220-32-1664 Usual Residence of Decedent Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No **Funeral Director** orchester 10f. Zip Code <, 10g. Citizen of What Country? 10e Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 613 2 USA Rece - American Indian, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify þ 3 Widowed 4 □ Divorced Black Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) anning Industr 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Stiles oun inton Minnie Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 20b. Place of Disposition (Name of cametery, cremetory or other place) -703 High St, ambridge, MD, 21613 Delema AMes 20e. Method of Disposition Dete 1 1 Burial 2 □ Cremation 3 □ Removal from State Cemetery 6/8/2000 Cambridge Bethel 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facilities Henry Fund 21. Signeture of Funeral Service Licensee Home uneka 510-Washington St. Cambridge, MD, 21613 Approximete Interval Between Onset and Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one ceuse on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Box 68760 Physician/Medical Due to (or as a consequence of): 080 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed page 2 s 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 1 Inpatient edical Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death To the Hospital or Attending PI within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end plece, and due to the ceuse(s) end manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certified 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 5 arrou 4 mmas 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State JUN 0 7 2000 Registrar

Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible.

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 1 1

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Funeral Director	203 32 4230	9x □ M 2K) F 7. Age (In y. 82	rs. last birthday Yrs.	If Under 1 Year   Montha   Deys	If Under 24 Hrs Hours Min		j, 1918	9. Birthplece (State or Foreign Country)
and mand	Usuel Residence of Decedent  10a. Stete 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limita
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be lied dother event.	17. Fether's Neme (First, Middle, Last)					me (First, Middle	, Maiden Sumen	
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and 2 sh eath and n 27 is m	19e. Informent'a Neme/Reletionship (7 Mr. Grover Adkins (Hus	band)	5654 K	avon Avenue	and Number or Rie Baltimo	re, Maryla	er, City or Town, and 21206	Stata, Zip Code)
Baltimore, Maryland 2: permit Pages 1 and 2 should be lifed w Cepariment of Health and Mental Hygies important: If them 27 is marked other to any injury or other traumatic event, in once.  To Be Cor	20e. Method of Disposition 1 ☐ Burial 2XXCremetion 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify,	Removel from Stete	cemetery, cre	osition (Name of metory or other ple vice Corpor		Dete 4/2000		City or Town, State lary land
Ball permit copur moon may in	21. Signature of Fundamy Service Lights	Sech In		2. Name end Addre		305 Harfor	rd Road B	Balto. Md. 21214
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/Medical Examiner	Immediate Cause (Final disease or condition rasulting in deeth)	a SEPSIS/ 5	MALL B		CHIEMIA	1		Onsat and Death
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68760, filcete be executed 3 physician and as the buriel-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c	(or as a consec					
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P.O. BOX net the death certified by the attending etached for use a Physician/M	Part II. Other significant conditions co	ntributing to death but not re	esulting In the u	underlying cause give	ven in Pert I.	23b. Did	tobacco use co	ntribute to the cause of death?
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aw requires been 2 should						24a. Wes	en eutopsy ormed?	24b. Ware autopsy findings available prior to completion of cause of death?
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/ita	25. Wes case referred to medical examinar?	lospitel:		100		eth (Check only	ona)	
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1 5 5 5 O	4 Homicide determined	28e. Plece of Injury - At building, etc. (Special Control of the base of the b	city)			City or To	wn, Stete)	
he Hospin 24 houspin 2	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my ki ner: On the basis of exami end mannar stated.	nation and/or in	n occurred at the tire eveatigation, in my o	me, date end place ppinion, deeth occu	e, end dua to tha urred et the tima,	data and place,	and dua to the cause(a)
To the comple	29b. Signature and title of certifier  Domungu		H.D.	29c. Licens	3 4 55	_		d (Month, Day, Year)
	30. Name and address of person who or DOM NIPJE MALL		em 23a) (Type, CAVEN B	Print)		MORE		
State Begistrar	31. Dete filed (Month, Day, Year)	32. Registrer's Sig	netura	Ara H	į.			

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ANDERSON

Registrar DHMH 16 Rev 6/95

RAYMOND W. WILSON M.D. 6565 N. Charles St. Shite 416, Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

31. Dete filed (Month Pox. 2000 2000

## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 5th Zuo Beitler Month **Physician** 11:00 pm Hel en June /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** Hospital HOPKINIS Baltimore
If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Day, Year) The Johns If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months | 1 ■ M 2 🖾 F 212-28-3971 68 Director Jan. 16,1932 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 25e-f shor 1 ☐ Yes 2 XNo Funeral Directo ital Hygiene. d other than "natural", or fleme 23e or 25e-f event, the Medical Examiner must be notifie Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of Whet Country? 10a. Street and Number 629 Plymouth Road 21229 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Stetus Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Nurse State Government permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy, important: If them 27 is married other any Injury or other 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 80 John Jones Grace Metz 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John M. Beitler/ Son 1110 Gregory Avenue Baltimore, Maryland 21207 Saltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Buriet 2 Cremation 3 Removet from Stete Meadowridge Mem. Park 6/19/2000 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signeture of Funerel Santien Licenses Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Final Intracerebra days disease or condition resulting in deeth) Examiner Physician/Medicai Examiner 8 Coiling of intracerebral dus The law requires that the death certificate be executed attending physician and for use as the bunal-tran Due to (or es a consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Box 68760, of Rupture intracerebral Breurysm thet initiated events resulting in death) Last Due to (or as e consequence of): of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Ninknown þ 24b. Were autopsy tindings evaileble prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed page 2 certificate has 2 No 1 ☐ Yes 2 No 1 Yes Physician: 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospitel: 1 tnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To nous after death.

Neral Director: After this iffiled in by the funeral di this 27. Menner of Death 28a. Dete of tnjury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation or Attending 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) KES 000 erus. M.D. June 2000 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 600 North Wolfe Street, Baltimore, Maryland Hua, Sherwin 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JUN 2 0 2000 Registrar

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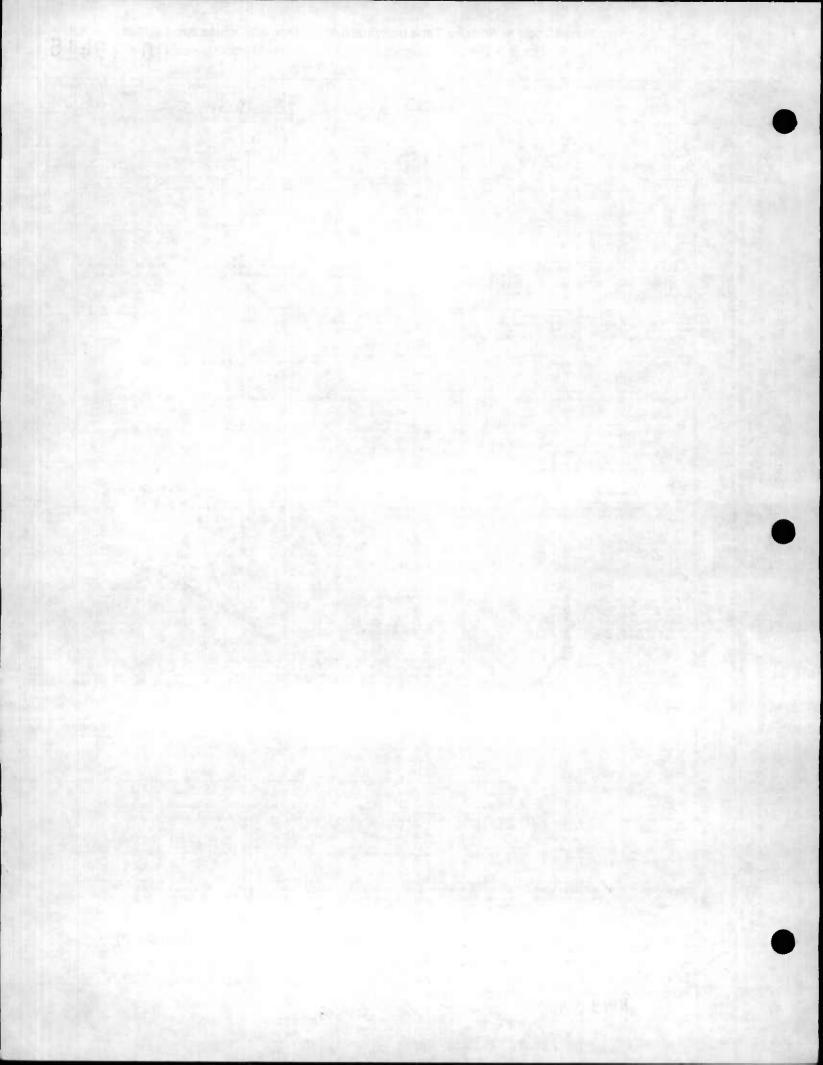
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/Medic Examin		4a Facility Name (					ter		4b. City, Town, o		th 4c. Coun	by of Death Balt	imore
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show		Usual Residence of 10a. State	Decedent 10b. County			10c. Ci	ty, Town or L	ocation	- 104				10d. Inside City Lim
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23a or 28 unt be not	Funeral Director	10e. Street and Nu		11 Av	renue			10f. Zip Code 212	07		10g. Citizen of USA		untry?
9,0	by	11. Marital Status  1 □ Never Marr  3 ☑ Widowed		ied 1 [	as Deceder med Forces Yas 2 Yes, Give ear or Dates	s? No	J,S. 13.	Was Decedent of If Yes, specify Cub		Specify Yes or North Rican, etc.)	o- 14. Re BI Spec	lack, White	rican Indian, e, etc. Lack
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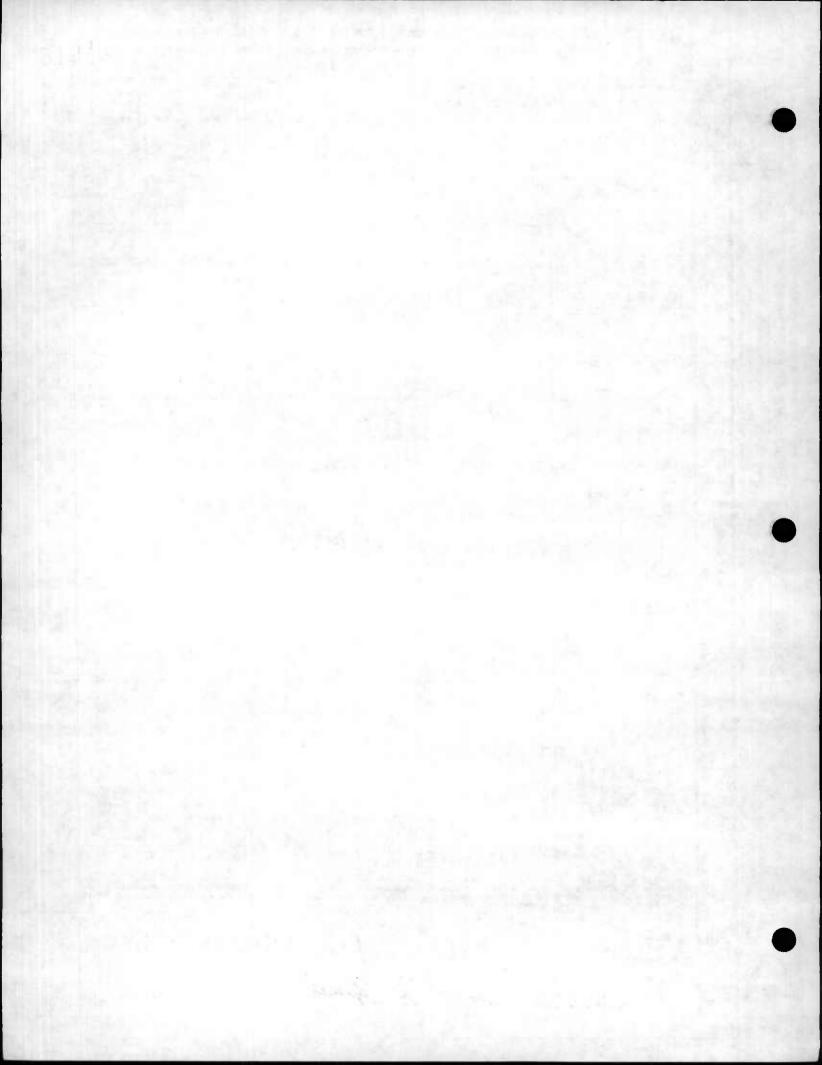
State of Maryland / Department of Health and Mental Hygiene [1] Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Buckingham **Physician** 18,2000 emue 12:30 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7. Age (In yrs. last birthdey) +1 HODKINS If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Month, Day Year) 11-21-1921 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 577-14-0281 10 M 20 F Nofth Carolina Yrs. Director 78 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than "natural". or Maryland enter traumatic averages. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Laurel 1 ☐ Yes 2 No MD Howard Funeral Director 10f. Zip Code 20723 10a Street and Number 10g. Citizen of What Country? 8029 McKenstry Drive 12. Wes Decedent Ever in U,S.
Arred Forces?

1 XYes 2 No
If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuben, Mexican, Puerto Rican, etc.)
 □ Yes 2 ☑ No Specify: Raca - American Indian, Black, White, etc. 1 Never Merried 2 Married 2 r Yes, Give Yeer or Dates: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Inspector 18. Mother's Name (First, Middle, Maiden Sumeme)
Maybelle Bliss 17. Father's Name (First, Middle, Last) Lemuel C. Buckingham 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete Zip Code) 7448 Flamewood Drive Clarksville, MD 21029 19a. Informant's Name/Reletionship (Type, Print) Kit Buckingham - Son 20b. Place of Disposition (Neme of camelery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition N Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/21/00 Newport, VA Mount Herman Cemetery 22. Name and Address of Facility Fleck Funeral Home 21. Signature of Funeral Service License MO0741 0 7601 Sandy Spring Road Laurel, Md 20707 ransia remmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respectively. Approximate Interval Between Onset and Death **Physician** ATTOM RAPPORTED BY WEIGHT COMMINGS /Medical Immediate Cause (Final days ematomo disease or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of). ESMITEN. Box 68760 Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Sease by 24a. Was an autopsy performed? 24b. Were autopsy findings svalleble prior to completion of cause of death? Completed certificate has 1 ☐ Yes 2 ☐ No spital or Attending Physician: Thours after death.
Inerel Director: After this certificative filled in by the funeral director, particular director, particu 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Yes 2□ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No June 14, 2000 9:00 PM 2 Accident fall at home 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 8029 McKen Stry Dr. 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide DOME To the Hospital within 24 hours a To the Funeral Completely filled 11 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. edical 29a. Certifier 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number JUNE 19,2000 RES -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARONZIK JOHNS HOPKINS 600 NORTH WOLFE STREET HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State JUN 2 0 2000 Registrar

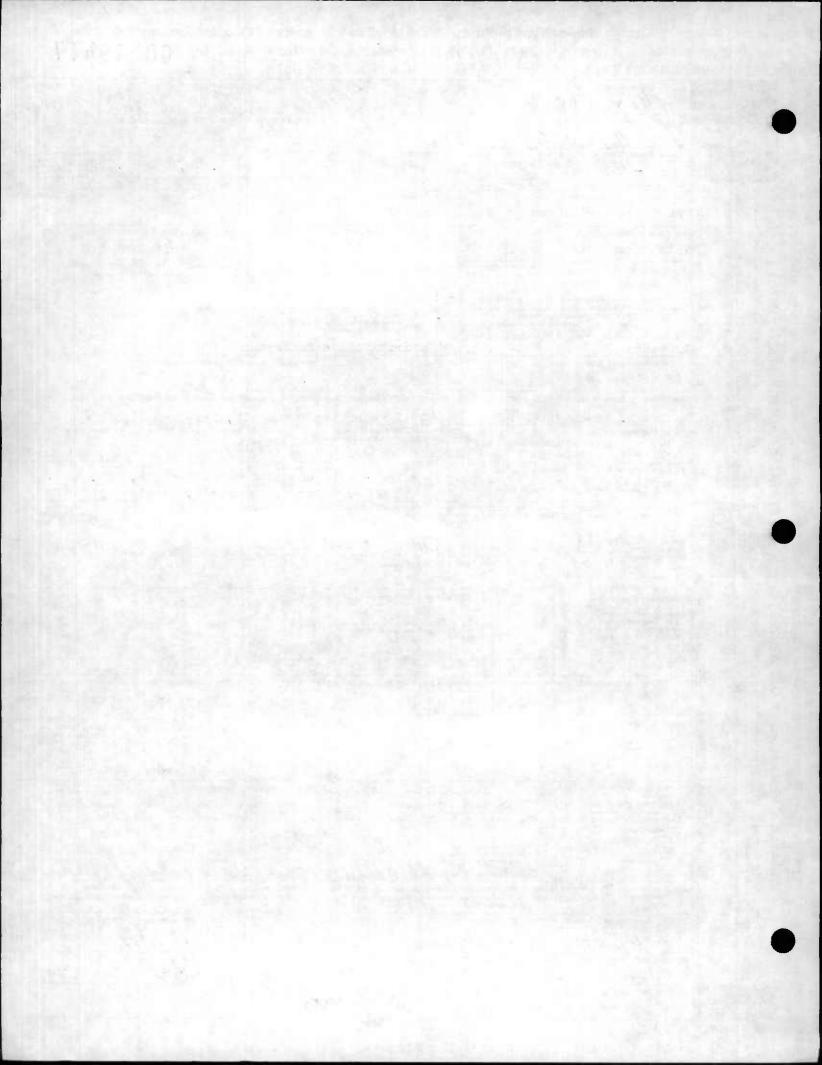


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	A	END#17 PER F.H. G784 6-	State of Maryland 22-2000 JAB		tment of F			giene ()	19417
4	hysician /Medical Examiner	1. Decedent's Name (First, Middle, Las EXAD) RT 4a Facility Name (If not institution, give	4	.10	Ba	DEW TOWN, OF A		Day Ye 20	00 2187AM
,	neral ector	5. Social Security Number 6. Sec. 212-48-2093	7. Age (in yrs. le	ast birthday) Yrs.	If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Sept. 2	N/A h, Year) 9.	Birthplace (State or Foreign Country) Pennsylvania
Maryland	incorded at	10a. State 10b. County  Maryland Baltimo:		Town or Local					10d. fnside City Limits 1 ☐ Yes 2√ No
h with the		10e. Street and Number 7621 Cedar Road		Hill	10f. Zip Code 21.222			10g. Citizen of Wha	
er de	Fune	11. Merital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	14	as Decedent of H Yes, specify Cubs	lispanlc Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indien, Vhite, etc. 'hite
1215- within 72 ane.	rt, the Medical Ex-	(Specify only highest grad	de completed) College (1-4or 5+)	(Give ki	O NOT use retired	duning most of work		16b. Kind of Busine	ess/Industry
E Se se se se se se se se se se se se se se	tic avant, in To Be Co	12 years  17. Father's Name (First, Middle, Last)  Michael Baren		Admirit:	scracive		e (First, Middle,	Maiden Sumame)	
or Heel	r other tr	19a. Informant's Name/Reletionship (7) Robert L. Bowen (Hi 20a. Method of Disposition 1√ Burial 2 □ Cremation 3 □ I	usband)  20b. Ple Cemoval from State	7621 ( ece of Disposi metery, creme	Cedar Ro	ad Dunda	Date Date	yland 212 20c. Location - City	22 y or Town, State
Baltimore,	important: eny injury phos.	4 Donation 5 Other (Specify, 21. Signeture of Funeral Service Licens  Johnnya Lites		22. Duo	F Faith Name and Addre da-Ruck 22 Wise	ss of Facility Funeral I	Home of	Rossvil Dundalk, , Marylan	
/Me Exar	sician edical miner	23e. Part it Enter the disease, or comp shock, or heart failure. List only of frimmediate Cause (Final disease or condition resulting in death)	a. hel		Bread	Colve		rest,	Approximate Interval Between Onset and Death
8 4	Joy the ettending physician and etached for use as the burist-transit.  Physician/Medical Examiner.	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	c	as a consequ					
	the ettending p shed for use as ysician/Med	Pert If. Other significant conditions co	ntributing to death but not resul	Iting in the unc	derlying cause giv	en in Part I.	23b. Dld	obacco uee contril	bute to the cause of death?
J 5	p p						24a. Wes		Probably 4 Unknown  4b. Wera eutopsy findings evailable prior to completion of cause
al Rec	m p						10,	res No	of death?
P P	: After this centricate a funeral director, pag	25. Was case referred to medical examiner?  1  Yes 25 No  27. Manner of Death 10 Netural 5 Pending 2  Accident Investigation		ER/Outpatient 28b. Time of fnjury	28c. fnjur Wor	4 LI Nursing H	ome 5 Resid	dence 8 Other (	Specify)
5 6 4	Led in by the funeral Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stree	et, factory, office		28f. Location (S City or Tox		or Rural Route Number,
the Hospital	2 2 2	(Check only 2 Medical Exami	afclan: To the best of my know iner: On the basis of examineti and manner stated.	riedga, deeth o on and/or inve	stigation, in my o	pinion, death occur	red at the time,	date and place, and	due to the cause(s)
To the within	N N	29b. Signeture end title of certifier  M. Purtell	Staff physics	can	29c. Licens	714		29d. Date signed (A	
19	State		Tell JURUM C 32. Registrer's Signatu	494 Ure /	O TEATE	err Ave	BALT	more mi	d 21224
A	legistrar	31. Date filed (Month, Day, Year) JUN 2 0 2	300 Senera		ppou	Ka			

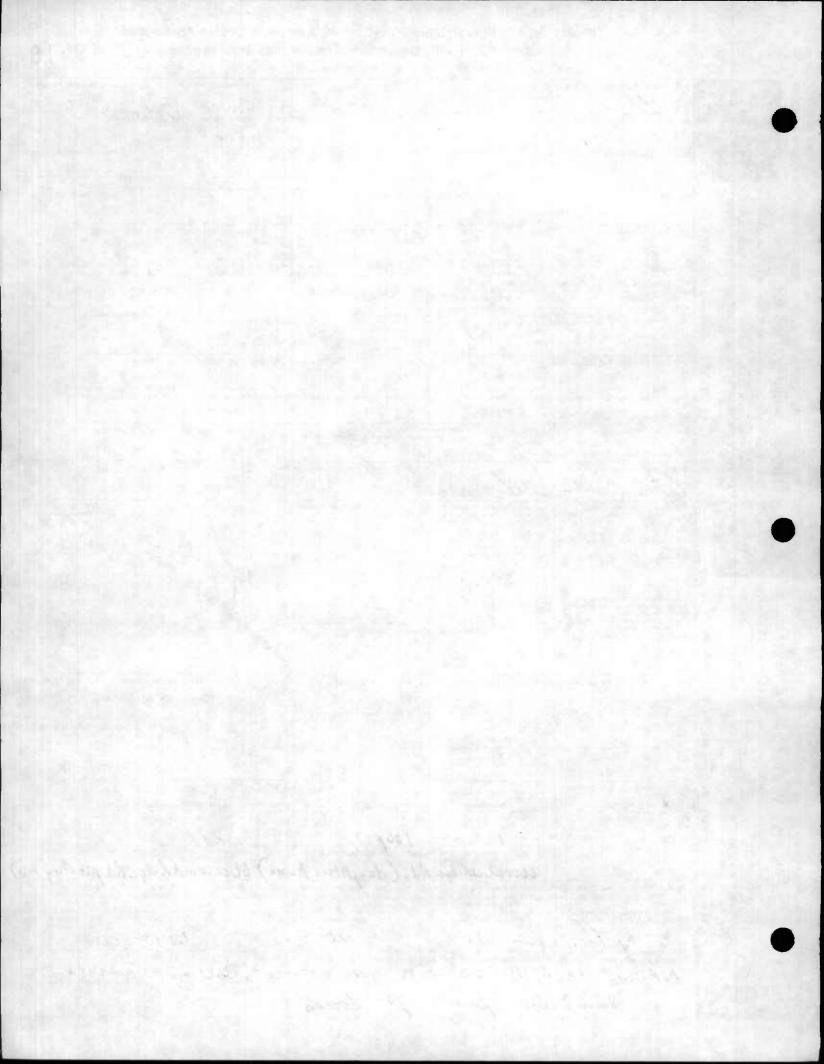
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State of Maryland / Department of Health and Mental Hygiene 00

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To B			Walte	r Gilbert Ti	imm			2011		Thelr	na Mattie F	Kundert	
anna a		nforment's Ne	eme/Relationship	(Type, Print)		19b. Meili	ing Address (S	reet end Num	ber or Run	el Route Numbe	er, City or Town,	Stete, Zip	Code)
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other other	20a. N	lethod of Disp			206	Place of Dispo	osition (Neme	of and and	-	Date	20c. Location	- City or To	own, State
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## Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year 0935 18,2000 ROTHY URCITORF 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPI MAZ OLUMBIA CIEN-Howaren DUNTY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Days 10 M 20 F Yrs. 88 Jan 18, 1912 214-64-7750 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Ellicott City Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21042 U.S.A 3822 Spring Meadow Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify. White 3 ☐ Widowad 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) Nina LeCompt James Allen Christopher 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19e. Informent's Neme/Relationship (Type, Print) 3822 Spring Meadow Court Ellicott City, Maryland 21042 Mr. George A. Burgtorf 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 06/24/00 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery 22. Nama and Addrass of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 M00535 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting to death) Due to (or as a consequence of) Infection RINBRY IRACT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): purenty Dua to (or as a consequence of): 23b. Did tobacco usa contributa to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth?

**Physician** /Medical Examiner

physician

cartificate has

After this

death.

within 24 hours after deat To the Funeral Director:

filled in

completely

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

show

or Herna 23a or 28a-f

pernit. Pages 1 and 2 should be filed within 72 hours after Departmant of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or he any injury or other treumatic event, the wed call Experimen

altimore, Maryland 21215-0020

must be notified at

Director

Funeral

Completed by

Be

2

death with the Maryland

Examiner

The law requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records.

or Attending Physician:

Hospital

To the

the buniel-transit by Physician/Medical for use as Completed page 2 should Certification: To Be 3

25. Was case referred to medical axeminer?

29b. Signature and title of certifier

1 Yes 2 No

27, Manner of Death

1 Natural
2 Accident

3 ☐ Suicide

29a. Cartifier

4 ☐ Homicide

(Check only one)

Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.
2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Monti

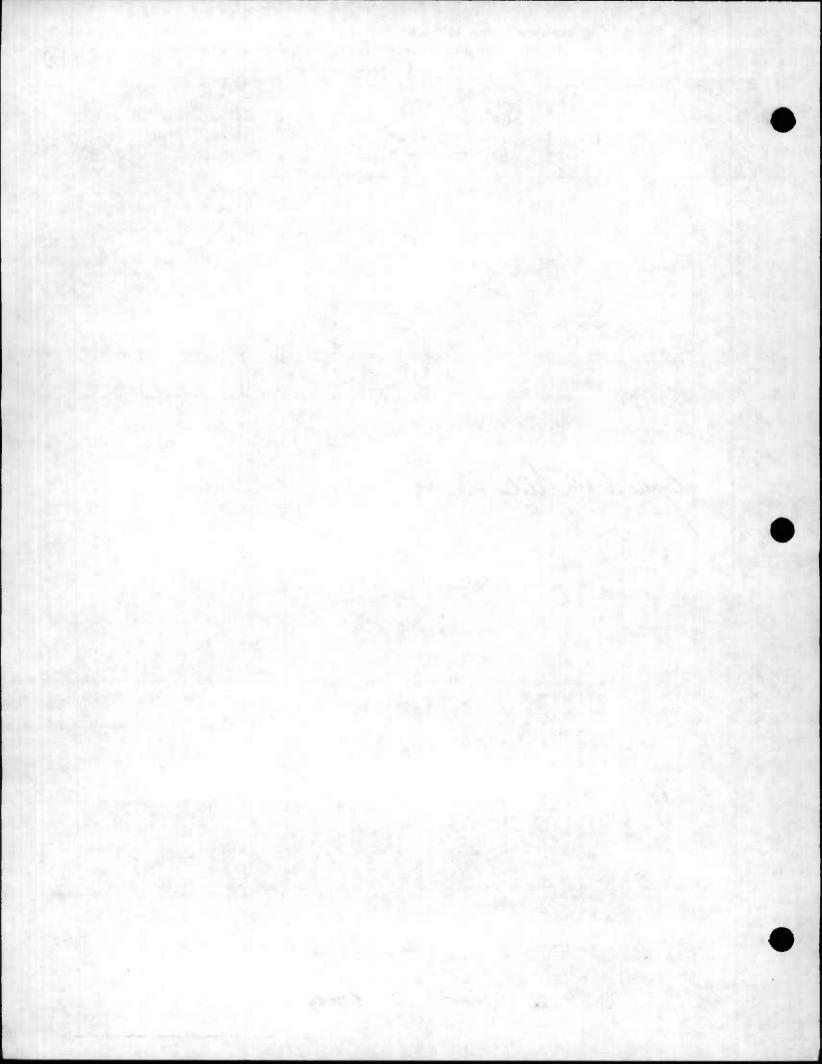
SHEIRIGH

5 Pending investigation

6 Could not be determined

9051 32. Registrar's Signature

NATIL PIKG, 46 BALAMORE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Alease D. Coleman 06 13 2000 3:00 a.m. /Medical 4a Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 4017 Ardley Ave. Baltimore N/A If Under 24 Hrs. 8. Dale of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1□M 2₩F 217-22-2288 76 Director 05-19-1924 Virginia Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hem 27 is marked other than "natural", or Nems 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director Md. N/A Baltimore 10e. Street and Number 10f. Zio Code 10a. Citizen of Whet Country? 4017 Ardley Ave. 21213 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Meritel Stelus pemit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygians. Important: If Item 27 is marked other than "natural", or he any lightly or other traumatic event, the Madical Empirica 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: Black à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Flementery/Secondary (0-12) 7 th College (1-4or 5+) Specialist Binder Md. Causulty Ins. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Charles Lambert Betty Burnett 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Bonita Coleman (Daughter) 4017 Ardley Ave. Balto., Md. 21213 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removel from State 6-15-00 Woodlawn, Maryland King Memorial Park Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Caple Funeral SErvice Funeral Service Licenses 5502 Winner Ave. Balto., Md. 21215 iplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown been signed is should be det Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending

Box 68760, P.0. Records, Division of Vitai

Baitimore, Maryland 21215-0020

The law requires that the death certificate be assecuted or Attending Physician:

n 24 hours effer death.
Ne Funerel Director: Affe To the Hospital o within 24 hours of To the Funeral DI completely

**DHMH 16 Ray 6/95** 

this

State Registrar

Medical

Louis Wieh 31. Date tiled (Month, Day, Year) JUN 2 0 2000

29b. Signature and title of certifier

2 Accident 3 ☐ Suicide

4 Homicide

(Check only one)

29a. Certifier

investigation

6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS

HOPKINS ONCEL66 Y 32. Registrar's Signature

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

deterritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

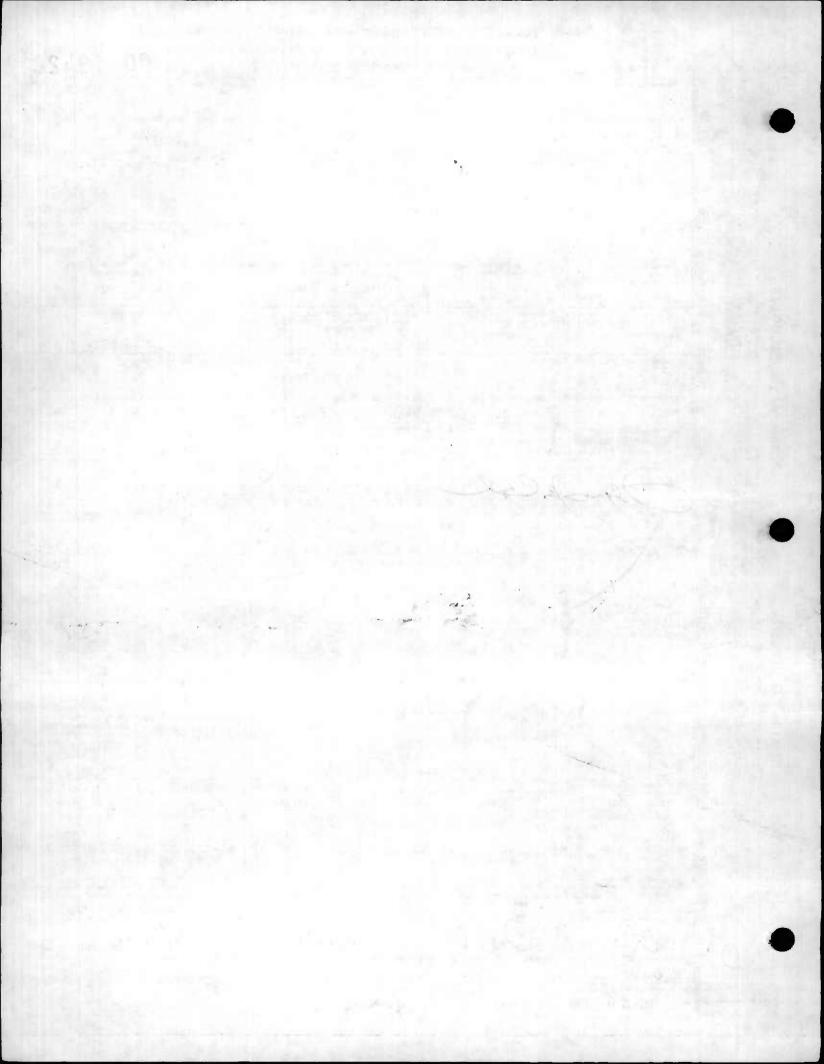
29c. License number

32671

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

**ORIGINAL** 



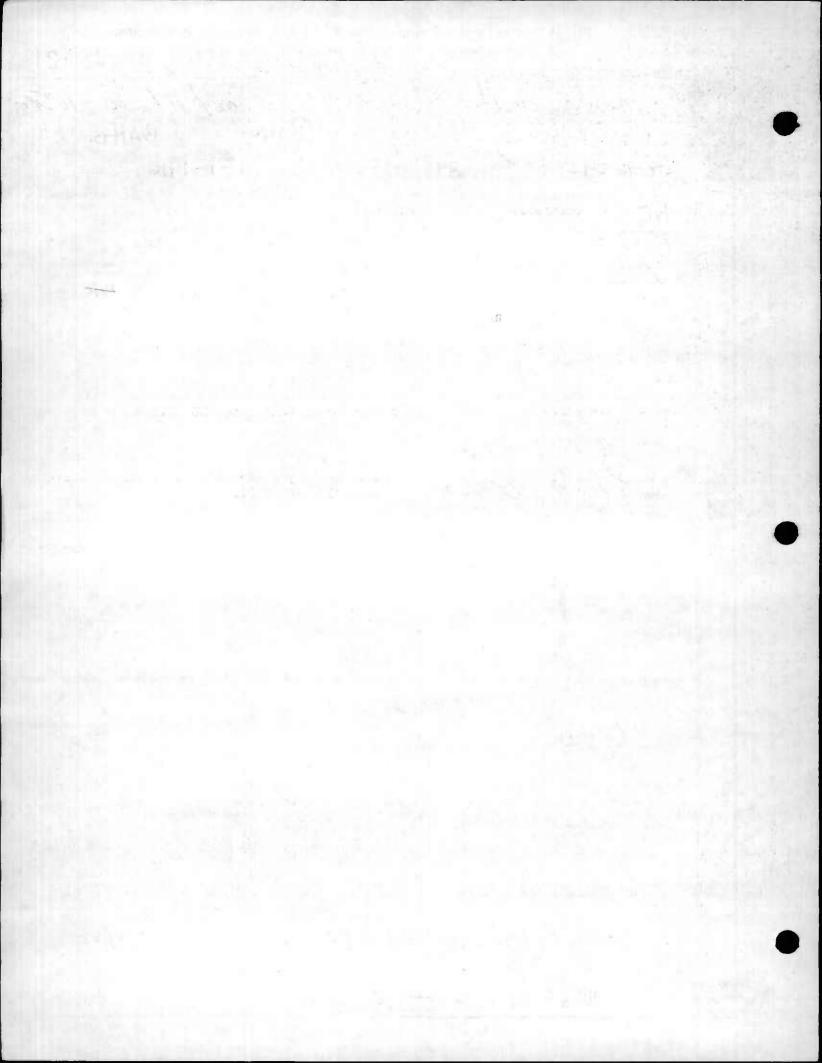
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #14 PER ANATOMY BOARD G784 6/20/2000 AH I. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month 045m **Physician** Mary 2000 06 /Medical 4e. Facility Name (If not institution, and street and number) 4b, Pity Town, or Location of Deeth 4c. County of Death **Examiner** BAH if Under 24 Hrs. If Under 1 Year Months Days 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Hours 218-96-0862 Director unk Usuel Residence of Decedent with the Maryland permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health end Mentel Hygiana. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Excriment must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8710 Emge Road 21204 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, spacify Cuben, Mexican, Puerto Rican, etc.) 11. Marita Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: BLACK Specify: à 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be unk unk 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Genesis Eldercare 8710 Emge Road Baltimore, MD 21234 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 🛛 Other (Specify) in state 21. Signature of Fungral Service Licensee 22. Name end Address of Fecility Director Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Patt1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate interval Between Onset and Deeth Physician Immediate Ceuse (Final disease or condition resulting in death) /Medicai Examiner Due to (or es a consequence of) Examiner signed by the ettanding physician and d be detached for use as the bunal-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting In deeth) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medicai Due to (or as a consequenca of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Aguatum Prum 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy peen certificeta has 2 10 No 1 Yes 2 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) examiner? Other: 4 Universing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 27. Menger of Death 28a. Date of injury (Month, Dey Year) 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: of or Attending Part of the death. 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not ba determined 3 Suicide in by t 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide To the Hospital o within 24 hours eff To the Funeral Di completaly filled in 29a, Certifier 12 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as steted. Medical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the ceuae(s) end manner steted.

29c. License number

29d. Date signed (Month, Dey, Yeer)

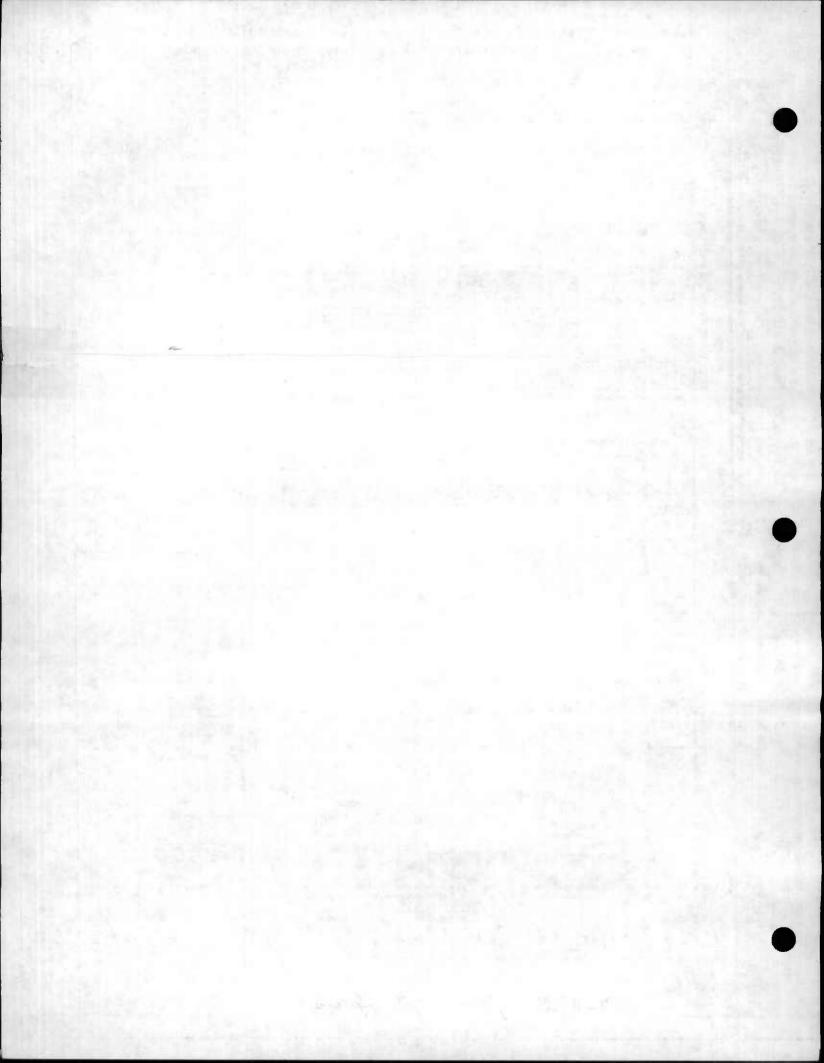
State Registrar 29b. Signature end title of certifier

31. Dete filed (Month, Day



State of Maryland / Department of Health and Mental Hygiene 00 101.22

Physician	Decedent's Name (First, Middle Zelma Simon							2. Date of Dea	12 <sup>Pay</sup> 200	) Öear	3. Time of De 1:00 at
/Medical Examiner	4a Facility Name (If not institution	n, give street and numb	per)	_		41	o. City, Town, or	Location of Death			
LAdillilei	BROADMEAD						Cockes	vville		altim	nore
Funeral Director	5. Social Security Number 579–20–0021	6. Sex 1 ☐ M 2 🖾 F	Age (In yrs. la	st birthday) Yrs.	If Under 1 Y Months D	ear ays	If Under 24 Hrs Hours Min.	8. Date of Birtl	h v. Year)		olace (State or Fo
show ed.et	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					1	I0d. Inside City L
28a-f at notfiled rector	MD Ba	ltimore		Cock	eysvill	.e					1 □ Yes 25
\$ B	10e. Street and Number 13801 York Roa				10f. Zip Co		2103	30	10g. Citizen of V US		ntry?
	3 X Widowed 4 □ Divorced	12. Wes Deced Armed Forc 1 Tyes 2 If Yes, Give Year or Date	X No		Vas Decedent I Yes, specify I □ Yes 2🌠		spanic Orlgin? (S n, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	k, White,	ean Indian, etc. hite
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th and Mental Hygiene. 7 Is marked other than traumatic event, the Merchan To Be Comp	12 17. Father's Name (First, Middle,	Last)	2		secre			me (First, Middle,	Maiden Sumam	UNK.	
and Mental Hygi s marked other sumstic event, To Be Co	John C. Simon						Alma E	Banning	~		
M pur	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	g Address (Si	reet a		ural Route Numbe		State, Zip	Code)
Health a em 27 is other tra	Broadmead			1380	1 York	Ro	ad Coc	kesyville	e, MD 2	21030	
Department of Health important: If hem 27 any injury or other to more	20a. Method of Disposition  1  Burial 2  Cremation  4  Donetion 5  Other (S		CO	aca of Dispo metery, cren	sition (Name on atory or other	place	a)	Date	20c. Location -	City or To	own, State
ng physician and set the burial-transit as the burial-transit and wedical Examiner	Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b	Due to (or	as a consequence as a c	uence of):	C	CANC	ER			17mo
its has been signed by the attending phage 2 should be detached for use as the completed by Physician/Med	Pert II. Other algnificant condition	d				e give	on in Part I.		lobacco use co Yes 2 No	ntribute to	o the cause of d
cata has been sig page 2 should b	1000							perfo	an autopsy rmed?	ev co ot	ere autopsy find allable prior to impletion of caus death?
	25. Was case referred to medica						OS Place 4 Pa	1 D Y		10	☐ Yes 2☐ No
this certific ral director,	examiner?	Hospital:	patient 2 DE	R/Outpatier	t 3D DOA	Othe	ur.	ath (Check only o		ar (Specii	(v)
After th funeral	27. Manne of Death  1 DNatural 5 Pandir  2 Accident investi	28a. Date of (Month,		28b. Time of Injury		Injury Work			now injury occur		,
Par spet	3 Suicide 6 Could determ	ined 288. Placa of building	Injury - At hor , etc. (Specify)					City or Tow	vn, State)		al Route Number
24 hours Funeral letely filled dical Co		g Physician: To the be Examiner: On the bas and manne	is of examination	on and/or In	estigation, in	my op	e, date and plac pinion, death occ	urred at the time,	date and place,	and due t	o the cause(s)
To the comple	29b. Signature and title of certifie	a Car	roll	2, M.	Q 29c. Li	cense	number 3 7 3 9 6	2	29d. Date signe	d (Month,	Dey, Year) 2000
	30. Name and address of person BARBARA (	ARROL	of death (Item	23a) (Type,	1380	) /	V01	RK R	D., CO	CKE	<1/51/1



ASP Physician /Medical	1. Decedent's Name (First, Middle, Last)  Elizabeth A. Cunningho  4a Facility Name (If not institution, give street and number)	Cer	tificate of		2. Date of D Month JUNE	Reg. No.	Year 2000 ty of Deeth	3. Time of Death 1530
Examiner	3318 BRENDAN AVE			BALTIMOR		100	n/a	
Funeral Director	219-32-3564 1DM 201F	(In yrs. last birthdey) 64 Yrs.	ff Under 1 Yea Months Days		(Month, Day, Year) C			place (State or Foreig intry) ryland
Maryland ef show fled at tor	Usual Residence of Decedent  10e. State 10b. County  Maryland n/a	10c. City, Town or Lo				104		
th with the Ma 23e or 28e-f1 unt be notified	10e. Street and Number 3318 Brendan Avenue		10f. Zlp Code 2121	3		10g. Citizen o		
Urs after dea est, or items Examiner in by Funer	11. Meritel Stetus  1 Never Merried 2 Married  3 Modowed 4 Divorced  12. Was Decedent Every Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 🛣 No	Hispanic Origin? (S ben, Mexican, Puerl Specify:	pecify Yes or No Rican, etc.)	Spec	ack, White	ican Indien, , etc. <b>Ihite</b>
I Z1Z15-U0ZU  od within 72 hours at ygiene. wer then "natural", or it, the Medical Exam  Completed by it	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Deced (Give lite. L	tent's Usual Occu kind of work done OO NOT use retire Supervi	upation e during most of word ed) SOL	rking	16b. Kind of	Business/li	
Maryland 2 d 2 should be filed in and Mental Hyg I te merked other treumetic event, I	17. Father's Name (First, Middle, Last) Ferdinand Foertsch		Capouro	18. Mother's Ner		1	ame)	9
Baltimore, permit. Pages 1 and Department of Healt Important: if Item 2 and a siny Injury or other ance.	Joseph Franklin Foertsch / College   20a. Method of Disposition 1	20b. Place of Dispo cemetery, cren Greenmou	sition (Neme of natory or other pl nt Cremo Neme and Addi Schumun	ece)	Date 5/16/00 L Home,			
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused it shock, or heert failure. List only one ceuse on each line Immediate Cause (Final disease or condition resulting in death)	the death. Do not enter	er the mode of dy	ring, such es cardial	or respiratory	arrest, the	105	Approximete Interval Between Onset and Death Clero H
OX 68760, certificate be executed reling physician and use as the burial-transit as the burial-transit awdedical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as e conseque to (or as e conseque to (or as e conseque)		xan	Dis	eas		
i, P.O. BOX 61 that the death certific, set by the attending pl o detached for use as: y Physician/Mec	Part II. Other eignificant conditions contributing to death but	not resulting in the un	nderlying cause g	iven in Part I.				to the cause of death
If Records, P.O. Box 68  The law requires that the death certifical are has been signed by the attending phyage 2 should be detached for use as the Completed by Physician/Med					ber	is en autopsy riormed?	0	Vere autopsy tindings valiable prior to completion of cause death?  Yes 2 No

Division of Vita

					24e. Was en autopsy performed?	24b. Were autopsy tindings available prior to completion of cause of death?  1 ☑ Yes 2 ☐ No
5. Was case referred to medical examiner?				26. Plece of D	eeth (Check only one)	
1X Yes 2 No	lospitel: 1 ☐ Inpatient 2 ☐	Other: 4 Nursing	Home 5 ☐ Residence 6 XOti	ner (Specify) SCENE		
7. Manner of Death 1. Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	M 28	lc. Injury at Work? 1 Yes 2 No	28d. Describe how injury occu	rred
3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stree	t, factory,	office	28f. Location (Street end Num City or Town, State)	ber or Rurel Route Number,

State

29c. License number 29d. Date signed (Month, Dey, Year)

29b. Signatible and title of certifier

O.C.M.E

JUNE 15,2000

SCON PCS Tower 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Dey, Year)
JUN 2 0 2000

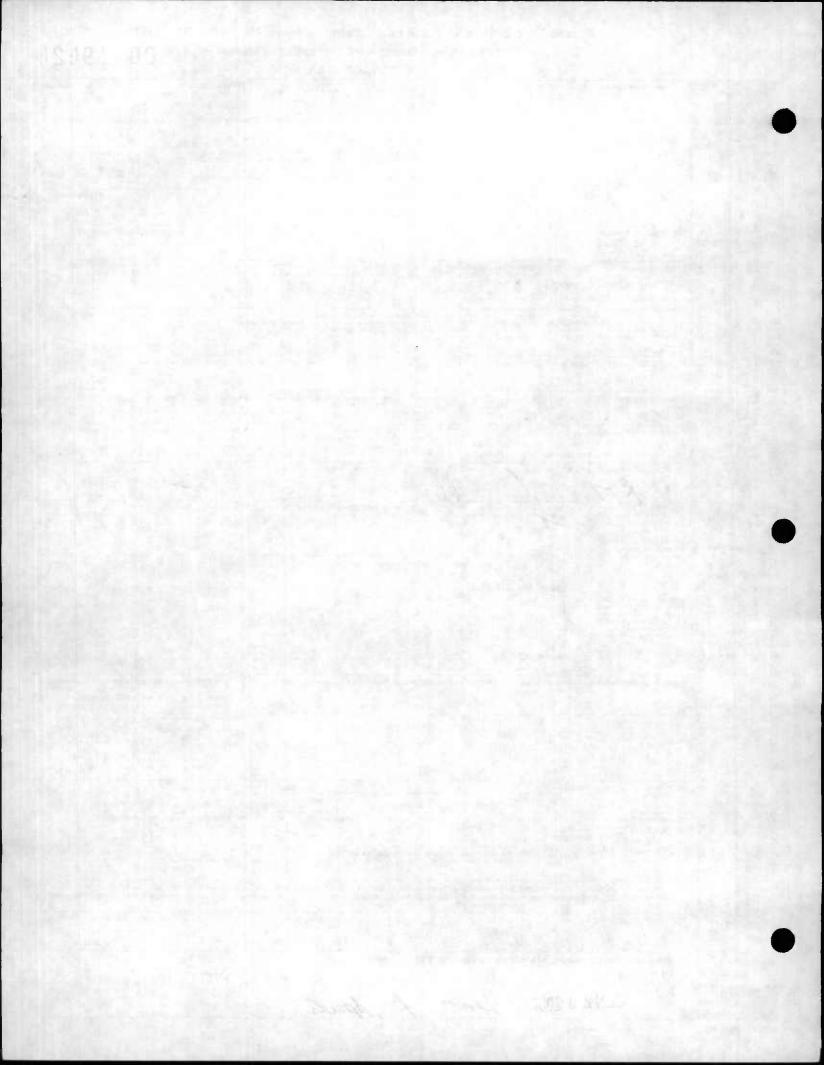
32. Registrar's Signature

Registrar DHMH 16 Rev 6/95



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				ar y land 7	Certifica		Death		Reg. No.	)	9424
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 220 pm Dora Lee Chayt un 2000 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Yeer 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Dec. 24, 1911

9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 1□M 25 F Months Days Hours Yrs. 578-26-0766 88 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MaRYLAND | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9018 Woodland Drive 20910 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 11. Maritat Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3K Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Retailer Clothing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Robins Rose Meverhoff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Kenneth A. Chayt, Son 6583 Zoysia Court, Alexandria, Virginia 22312 June 14 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King David Memorial Gdns. 2000 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA 21. Signature of Funeral Service Lic 22. Name and Address of Fecility Pearson Funeral Home arman 472 North Washington St., Falls Church, VA 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Cardio -Due to (or as a consequence of): erunory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) chronic 5tage end Due to (or as a consequenca of): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably \$ ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 2 No. 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Box 68760 certificate be Records, Vital Hospital or Attending Physician: Division To the Hospital or within 24 hours aft To the Funeral Di completely filled in

State Registrar

31. Date

**Physician** 

/Medical

Examiner

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29b. Signature and title of certifier

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certificate

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Director:

3altimore, Maryland 21215-0020

**DHMH 16 Rev 6/95** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONSUE To

32. Registrar's Signature

Road

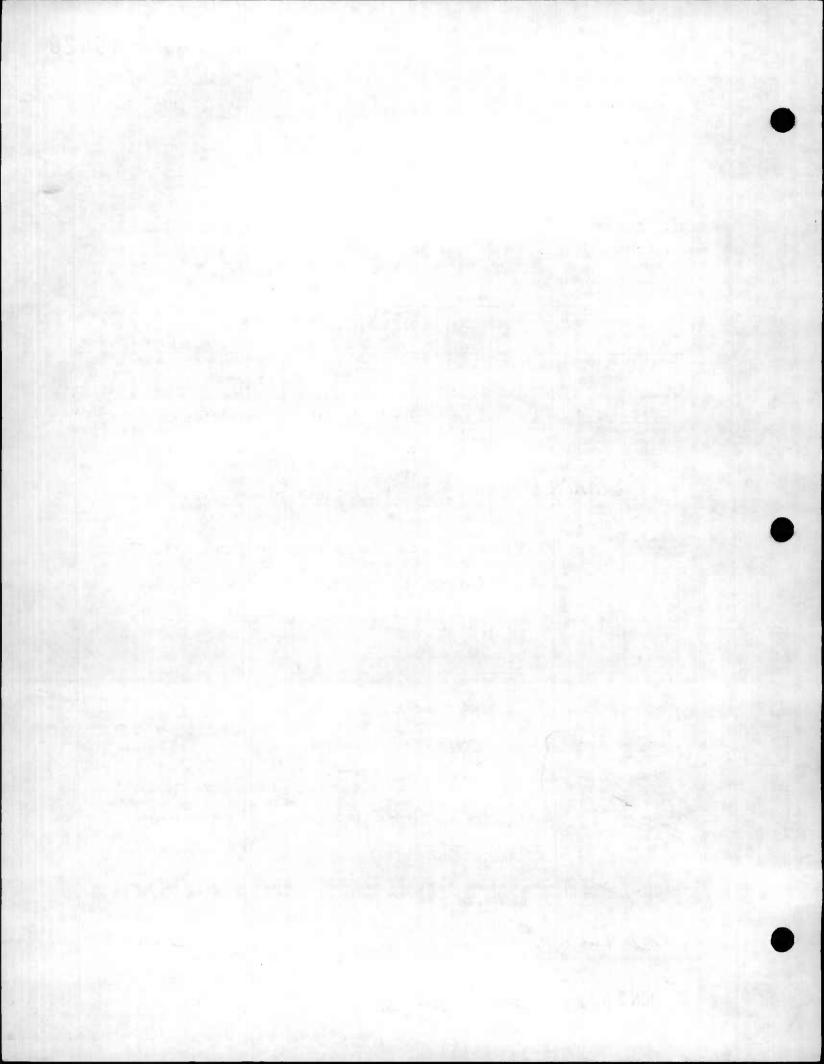
29c. License number

POUCNTL

D: 4490)

29d. Date signed (Month, Day, Year)

ALVEREZ, MO



State of Maryland / Department of Health and Mental Hygiene 0 19427

	Certificate of Death	Re	eg. No.	13421
Physiciar /Medica		2. Date of Death	Day Yaar	
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Funeral Director	212-10-02/9 10 m 28F 83 Yrs.	Hrs. 8. Date of Birth Min. (Month, Dey, July 7, 1	9. B	irthplace (Stete or Foreign
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pemit. Peg Department Important: If any Injury o	21. Signature of Funaral Sarvice Licensee Ronald S. Wade, Director per DVR  22. Nama and Address of Facility State Anatomy Board, Baltimore, MD 21201	655 W. Baltin	more Street	
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Toth within Toth	29b. Signature and title of contiliar 295 2MD D450	+71 2	9d. Date signed (Mod	9-2000
	30. Name and address of person who complated cause of death (Item 23a) (Type, Print)	1. D		
State Registrar	JUN 2 0 2000  32. Registrar's Signature			

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death with the Maryland Items 23s 72 hours after 6 2 should be filed within 7; and Mental Hygiene. permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If firm 27 is marked other any injury or other traumatic event poice.

Physician /Med at Laurniner

The law requires that the death certificate be executed attending physician and for use as the burial-trancate has been signed I page 2 should be det certificate Attending Physician: director, this After death. To the Hospital or Attand within 24 hours after death To the Funeral Director: the in by completely

State of Maryland Department of Health and Mental Hygiene [] 19428 AMEND ITEM: #24A PER Certificate of Death VERBAL RESPONSE G784 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death MAY 31, <sup>Day</sup>2000 EDWARD E. ECKMAN 11:33 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PERRY POINT CECIL VA MARYLAND HEALTH CARE SYSTEM If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foraign Country) 7. Age (In yrs. last birthday) Days 1KM 2□ F Hours Yrs. 73 FEb 28, 1927 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. toside City Limits MD Cecil Port Deposit 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Stayman Drive 21904

13. Was Decedant of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Hace - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none Apprasier automobile 17. Father'e Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David E. Eckman Angela W. Fair 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) VA MD Health Care System Bldg 361 Med Admin Perry Point, MD 21902

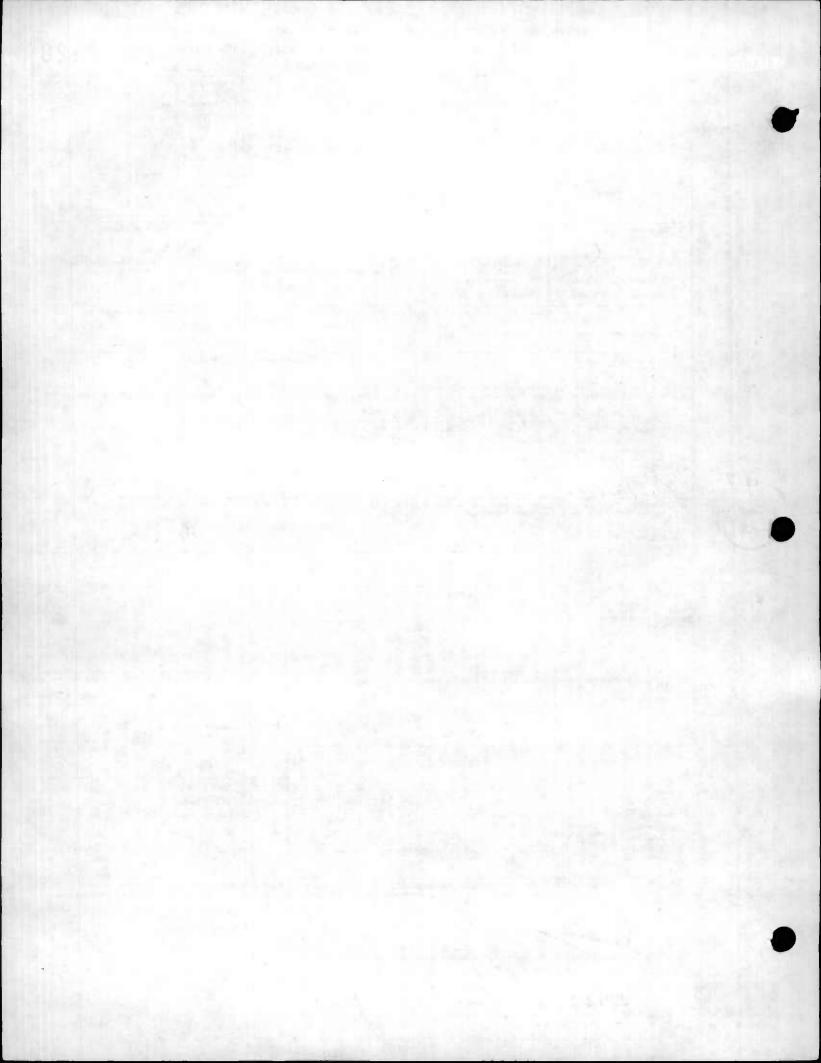
of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Buriat 2 Cremation 3 Removal from Stata
4 Donation 5 Other (Specify) 21. Signeture of Fureral Service Licensee Ronald S. Wade. 22. Neme and Address of Facility Director State Anatomy Board 655 W. Baltimore Street Reco Baltimore, MD 21201 Part. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, and, or heart failure. List only one causa on aach line. Approximate Interval Between Onsat and Death Immediate Cause (Final diseasa or condition rasulting in death) UNKNOWN a CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of) Physician/Medical Exam Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2KINO 3 Probably 4 to Unknown þ Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No 2XXNo 25. Wes case referred to medical 26. Placa of Death (Check only ona) Hospitel: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be datermined 3 Suicide 28e. Placa of tnjury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Medical 29a, Certifier 1 Certifying Phyalcian: To tha best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated. 29b. Signeture and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D39170 June 1, 2000 30. Name and address of person who completed cause of death (ttam 23a) (Type, Print) RAKESH MATHUR, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902 31. Dete filed (Month, Day, Year) JUN 2 0 32. Registrar's Signature State

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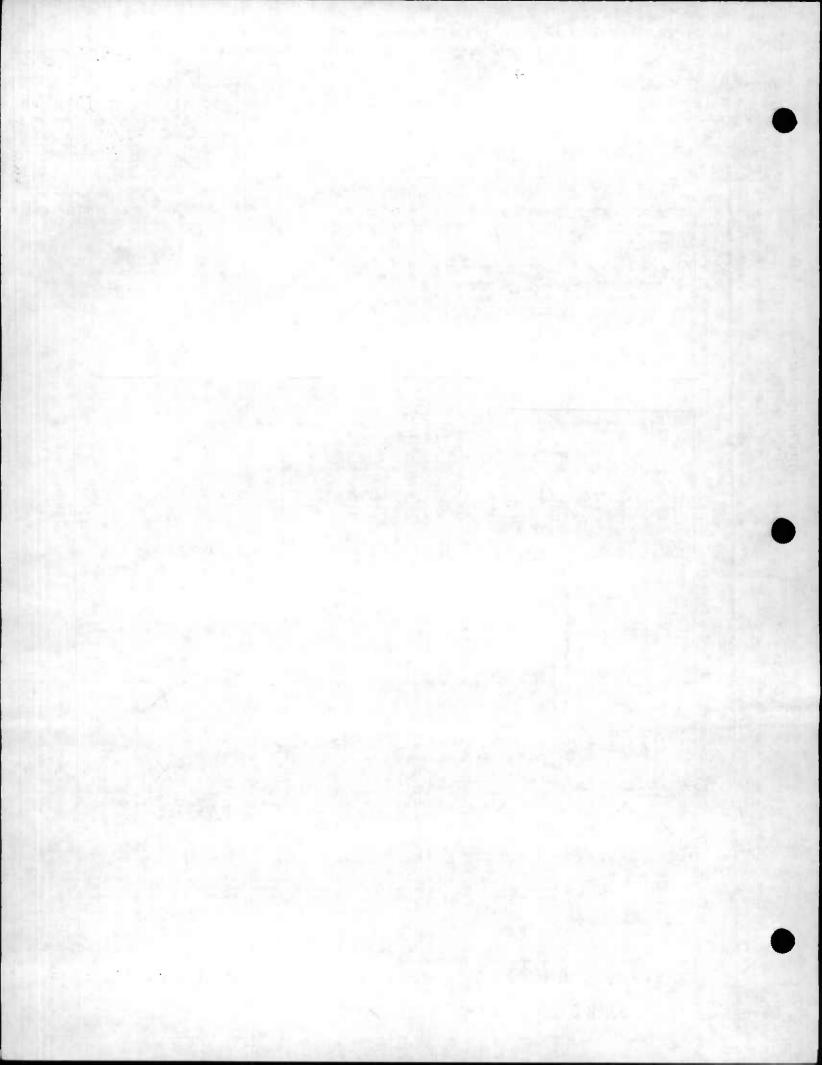
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		Residence of Decedent State 10b. County		10c Ci	ity, Town or L	ocation							10	d. fnside City Limits
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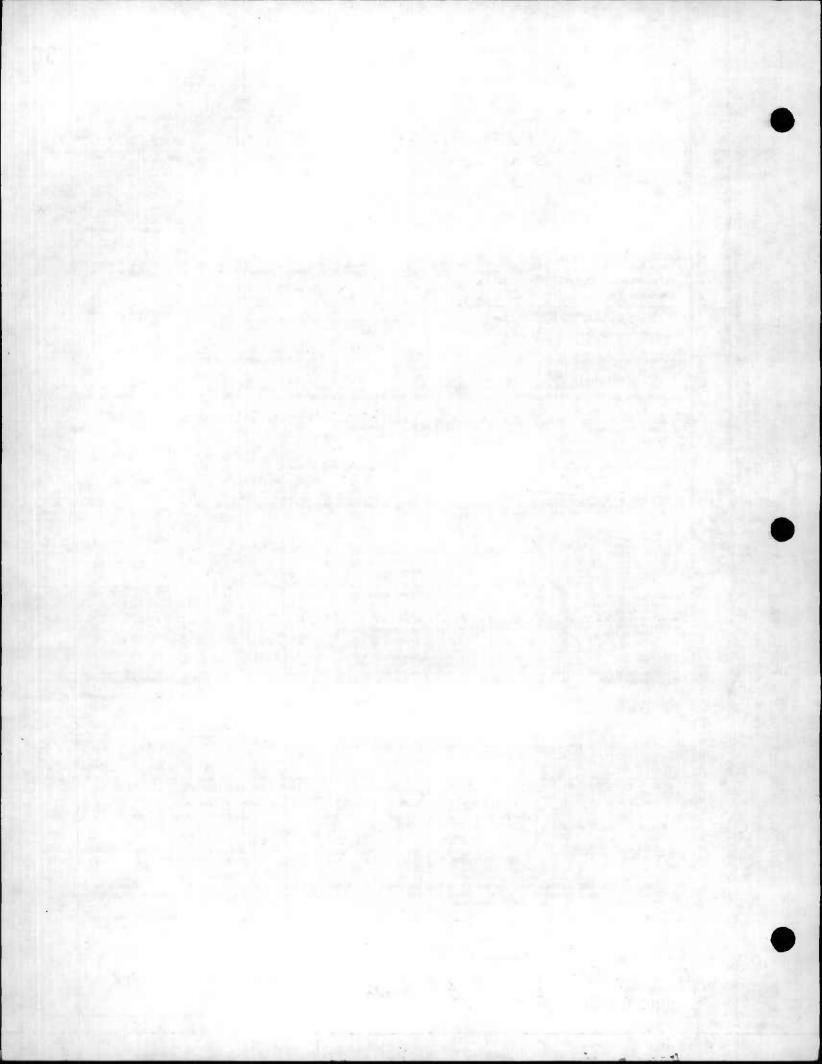
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Frank John Eisemann/ Son   8117 Edwill Avenue, Baltimore, MD   21237				State Zin Code)
20b. Place of Disposition 1 Partial 2 Circometron 3   Removal from Stele 4 Donastion 5   Other (Specify) 21. Signature of Funeral Septide Lichean 22. Same and Address of Facility Cvach/Rosedate Funeral Home 121. Chesaco Avenue, Baltimore, MD 22as. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, intervel Bereard Immediate Cause (Final essalting in death)  23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, intervel Bereard Immediate Cause (Final essalting in death)  24a. Part II. Other significant conditions, in death but not resulting in the underlying cause given in Part II.  25b. Due to (or as a consequence of):  26c. Place of Death (Check only one) 27c. Manner of Death 1   Majoritat 2   Majoritat 2   Majoritat 2   Majoritat 2   Majoritat 2   Majoritat 2   Majoritat 3   Majoritat 2   Majoritat 3   Majoritat 2   Majoritat 3   Majoritat 2   Majoritat 3   Majoritat				
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shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or conditions disease or conditions and beauting in death)  Let be to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):  Cause (Disease or injury at inlieted events resulting in death) Last  Due to (or es a consequence of):  Cause (Disease or injury at inlieted events resulting in death) Last  Due to (or es a consequence of):  Cause (Disease or injury at inlieted events resulting in death) Last  Due to (or es a consequence of):  Cause (Disease or injury at inlieted events resulting in death) Last  Due to (or es a consequence of):  1   Yes   28 No   3   Probably   4   Unknown of the cause of death of the cause of death of the caus				
Immediate Cause (Final disease or condition resulting in death)  Bue to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):  Cause (Disease or injury in death) Last  Due to (or es a consequence of):  Cause (Disease or injury in death) Last  Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):  Cause (Disease or injury in death) Last  Due to (or es a consequence of):  Due to (or es a consequence of):  23b. Did tobsecco use contribute to the cause of death injury es inj	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart tailure. List only one cause on each line.	or respiretory err	rest,	Intervel Between
Due to (or es a consequence of):    Sequentially list conditions, and state of the consequence of):   Sequentially list conditions, and state of the consequence of):   Sequentially list conditions, and state of the consequence of):   Congestive Heart Failure   Con	Immediate Cours /Final			Onset and Deeth
Due to (or es a consequence of):    Due to (or es a consequence of):   Due to (or es a consequence of):   Due to (or es a consequence of):   Due to (or es a consequence of):   Cangestive Heart Failure   Check only one    disease or condition a. Lere bro vas cylar need of the condition as Lere bro vas cylar need of the condition as Lere bro vas cylar need of the condition as Lere bro vas cylar need of the condition as Lere bro vas cylar need of the condition as Lere bro vas cylar need of the condition as Lere bro vas cylar need of the cylindrical needs of the cy	1+		1 Day	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    23b. Did tobacco use contribute to the cause of death   1   Yes   2   No   3   Probably   4   Unkn   24a. Wes en autopsy performed?   24b. Were autopsy tinding available prior to completion of cause of death?   1   Yes   2   No   1   Yes   No   Number of Injury   No   Number of North, Disy Year   No   1   Yes   No   Number of N	Due to (or es e consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    23b. Did tobacco use contribute to the cause of death   1   Yes 2   No 3   Probably 4   Unkn   24a. Wes en autopsy performed?   24b. Were autopsy tinding available prior to completion of cause of death?   1   Yes 2   No 1   Yes 2	Deep Vein Thrombosis			1
Due to (or es a consequence of):    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.   23b. Did tobecco use contribute to the cause of death   Yes 2 No 3   Probably 4   Unkn	if any, leading to immediate			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    23b. Did tobacco use contribute to the cause of death   1   Yes 2   No 3   Probably 4   Unkn   24a. Was an autopsy performed?   24b. Were autopsy the performed?   24b. Were a	Cause (Disease or injury c. Ongestive fleart 19,10,10			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to the cause of death 1   Yes 2   No 3   Probably 4   Unknown and the contribution of the cause of death 2   24b. Were autopsy inding available prior to completion of cause of death?  25. Wes case reterred to medicat examiner?  1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   Nature of the contribution of the cause of death?  27. Manner of Death	resulting in death) Last  Due to (or es a consequence of):			
1   Yes   2   No				
24a. Wes en autopsy performed?  24b. Were autopsy triding available prior to completed or death?  1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   No   Yesr)  25. Wes case reterred to medicat examiner?  1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   No   Yesr)  26. Place of Deeth (Check only one)  27. Manner of Death   Sea   Death of Injury   Yesr)   28b. Time of Injury   Yesr		1	In the ry and	
1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 1 Naturel 2 Naturel 3 Naturel 3 Naturel 3 Naturel 3 Naturel 3 Naturel 3 Naturel 4 North Naturel 5 Needing investigation 3 Name and address of person who completed cause of death (Item 23a) (Type, Print)  28a. Date of Injury 28b. Time of Injury et Work? 1 Naturel 5 Pending investigation 28a. Date of Injury - At home, ferm, street, fectory, office 28d. Describe how injury occurred work? 1 Naturel 5 Pending investigation 28a. Date of Injury - At home, ferm, street, fectory, office 28d. Describe how injury occurred 28d. De	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.			
25. Wes case reterred to medicat examiner?  1   Yes   2   No   1   Yes		יטי	es 2125 No	3 Probably 4 Unkr
25. Wes case reterred to medicat examiner?    1				24b. Were autopsy tindin
25. Wes case reterred to medical examiner?		pertor	med?	completion of cause
25. Wes case reterred to medical examiner?  1			- est	
examiner?    1	OS Was assessment to medicat			1 Yes 2 No
27. Manner of Death   Nature    S   Pending investigation   Suicide   Accident   Suicide   All Home   Suicide   Suicide   Suicide   All Home   Suicide   Sui	25. Wes case referred to medicat examiner?  Hospital: Other:			
2   Accident 3   Suicide 4   Homicide  28e. Place of Injury - At home, ferm, street, fectory, office  28e. Place of Injury - At home, ferm, street, fectory, office  28f. Location (Street end Number or Rurel Route Number, City or Town, State)  29a. Certifier (Check only one)  1   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner as stated.  29b. Signature end title of certifier  29c. License number 29d. Date signed (Month, Dey, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	129 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Ho			
29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted.  29b. Signature end title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  53547  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 Nature 5 Pending (Month, Day Year) Injury Work?	200. 0000100 11	ow injury occur	••
29a. Certifier (Check only one)  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner as stated.  29b. Signature end title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	3 Suicide 6 Could not be 28e Place of Injury - At home farm street factory office	28f Location (S	treet and Numb	er or Rurel Route Number
(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted.  29b. Signature end title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		City or Tow	n, State)	or or ribidiritotic rumber,
(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted.  29b. Signature end title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  53547  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		and due to the se	auss(s) and man	mar on stated
29b. Signature end title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  53547  29d. Date signed (Month, Dey, Year)  6116100	(Check only  Check	red at the time, d	late and place,	end due to the cause(s)
Magann Sun 53547 611600  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	· With the store of the store o	5	29d. Date signer	(Month, Dev. Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
			51.	
Dr. Saniay Jagannath 9000 Frankling Square Drive Balt: more, M.D. 21237			1000	
	te 31. Dete filed (Month, Day, Year) 32. Registrar's Signature		1	

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State of Maryland / Department of Health and Mental Hygiene 00

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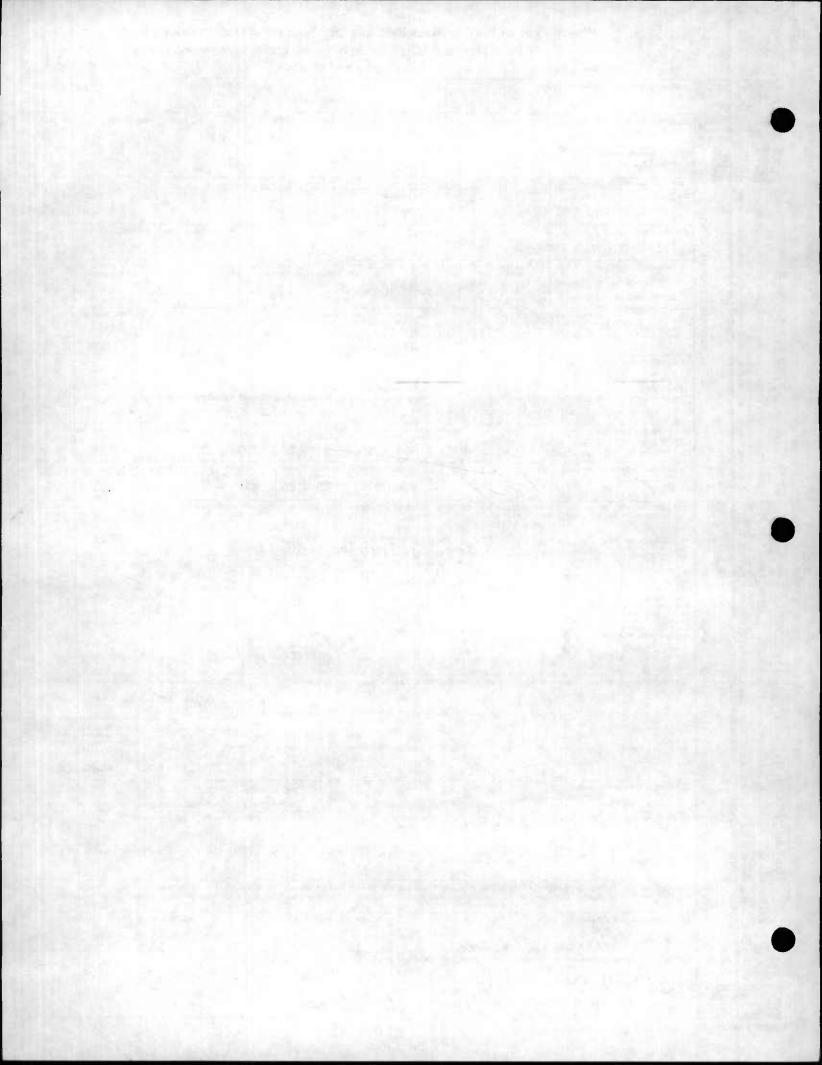


DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

sician	1. Decedent's Name (First, M			PLAN.			D.J. 7 %	2. Dete of De Month		Year	me of Deeth
edical	RUI					-	HMAN	June		2000 08	:11 A.M.
miner	4a Facility Name (If not institu		end number)	'enter			4b. City, Town, or 1	Location of Deat .lstown	· ·	of Death	
l r	5. Social Security Number 215-54-2536	6. Sex	7. Age (In	yrs. last birthday	/) If Undo	er 1 Year Days	If Under 24 Hrs. Hours Min.			9. Birthplace (S Country)	State or Foreign
4	Usual Residence of Deceden		1.0	0. 7							
*	MD BAL	TIMORE	10	c. City, Town or L		שמע					ide City Limits
Director	10e. Street and Number	TIMORE		DA	LTIMO	ip Code			10g. Citizen of \		7 100 225110
	714 WESTOVE	R ROAD			101. 2	ip Code	21208	- 41		S.A.	
by Funeral	11. Marital Status  1 Never Married 2 1 Nover 3 Widowed 4 Divor	Aarried 1	las Decedent Ever med Forces? Yes 2 No Yes, Give ear or Dates:	in U,S. 13	Was Dec		dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	Specify	e - American Indi ck, White, etc.	an,
peted	15. Dece (Specify only hij	dent's Education		16a. Dec	edent's Us	ual Occup	pation during most of wor	rkina	16b. Kind of B	usiness/Industry	ME D
Completed	Elementary/Secondary (0-1	-	ollege (1-4or 5+)			use retire	during most of word)				
	12 17. Father's Name (First, Mide	de lest)		OW	NER		18. Mother's Nar	na (First Middle		Y CLEANI	NG
Be C			MICANO	ALTONIO				ne (r irai, middle	, maideir Surrian		
٥	19a. Informant's Neme/Relati	ARLES PAL		PALISANO 19b. Mei		ss (Street	BELLE and Number or Ru	ıral Route Numb	er. City or Town	CAPLA State. Zip Code)	
	FRED RONALD			100			R ROAD -				
	20a. Method of Disposition			0b. Place of Disp	position /N	ame of	112-1	Date		City or Town, St	ate
	1XX Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe		al from State	AR SINA	Printed Laborate	Charles and Control	1	6/19/00	OWINGS	MILLS,	MD
	21. Signature of Funeral Serv	The state of the s	10			The second	ess of Facility			& BROS.,	
	* Paul	Jel	wol	8	900 F	EIST	ERSTOWN I	ROAD - F	IKESVIL		
	23a. Part1. Enter the disease shock, or heart feilure.	, or complication List only one cau	ns that caused the use on each line.	death. Do not er	nter the mo	ode of dyir	ng, such as cardia	or respiratory a	rrest,	Interv	eximate al Between and Death
n	Immediate Cause (Final		2		-1					1	and Death
al er	Immediate Cause (Final disease or condition resulting in death)	a	Tul	nonary	1hco	nbo-	- Embolis	M	4		
ě			Due	to (or as a conse	equence of	):	- Embolis bosis				
m in		b					bosis				
Examin	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying		Due	to (or as a conse	equenca of	).					
edicai	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C	Due	to (or as a conse	aquenca el	1:					
	resulting in death) Last		500	to (or as a conse	querica or	•				30	
cian		d									
ıysı	Part II. Other significant con-	fitione contributi	ing to death but no	ot resulting in the	underlying	cause gi	ven in Part I.		-	ntribute to the co	
y Ph								10	Yes 2 No	3 Probably	4 Unknown
Completed by Physician/M								24a. Was	an autopsy ormed?	24b. Wera aut available completic of death?	opsy findings prior to on of cause
E								16	Yes 2□No	1 Lives	2 No
BeC	25. Was case referred to med	ical	7.3419.4				26. Place of Dea	ath (Check only			
ToB	axaminer? POXYes 2 No	Hospita	al: 1  Inpatient	2 N ER/Outpatie	ent 3 C	OA Ott	hor:	lome 5 ☐ Resi		ner (Specify)	
	27. Manner of Death  1 Natural 5 Per 2 Accident inve	ading estigation	e. Date of Injury (Month, Day Ye			28c. Inju			how injury occur		
edical Certification:	3 ☐ Suicide 6 ☐ Co	uld not be ermined 286	e. Placa of Injury - building, etc. (S	At home, farm, s	treet, fecto	ry, office		28f. Location ( City or To	(Street end Numi wn, Stete)	ber or Rural Route	e Number,
lical C	29a. Certifier 1 Certification Check only one)	cal Examiner: O	: To the best of my in the basis of exa and manner stated.	/ knowledge, dea mination and/or li	nth occurre	d at the tid	me, dete and place opinion, deeth occu	a, and due to the arred at the time,	cause(s) and madate and placa,	anner es stated. and due to the ca	ause(s)
2	29b. Signature and title of cer	ifier			2	9c. Licens	se number		29d. Date signe	d (Month, Day, Y	ear)
X S	1:11	1	11.			0	C.M.E.		7	- 10 00	200
Med			1/1/1/2	0		( )	Calvi - F.		. 1111	ie ix 7	1(1(1)
Medical Certification: 7	30. Name and address of pers	on who complet	Chufe a	(Item 23a) (Type	e, Print)	0.	C.M.E.		Jur	ne 18, 20	000
Med	30. Name and address of pers	on who complet	Chufe in death				treet, Ba	ltimore			

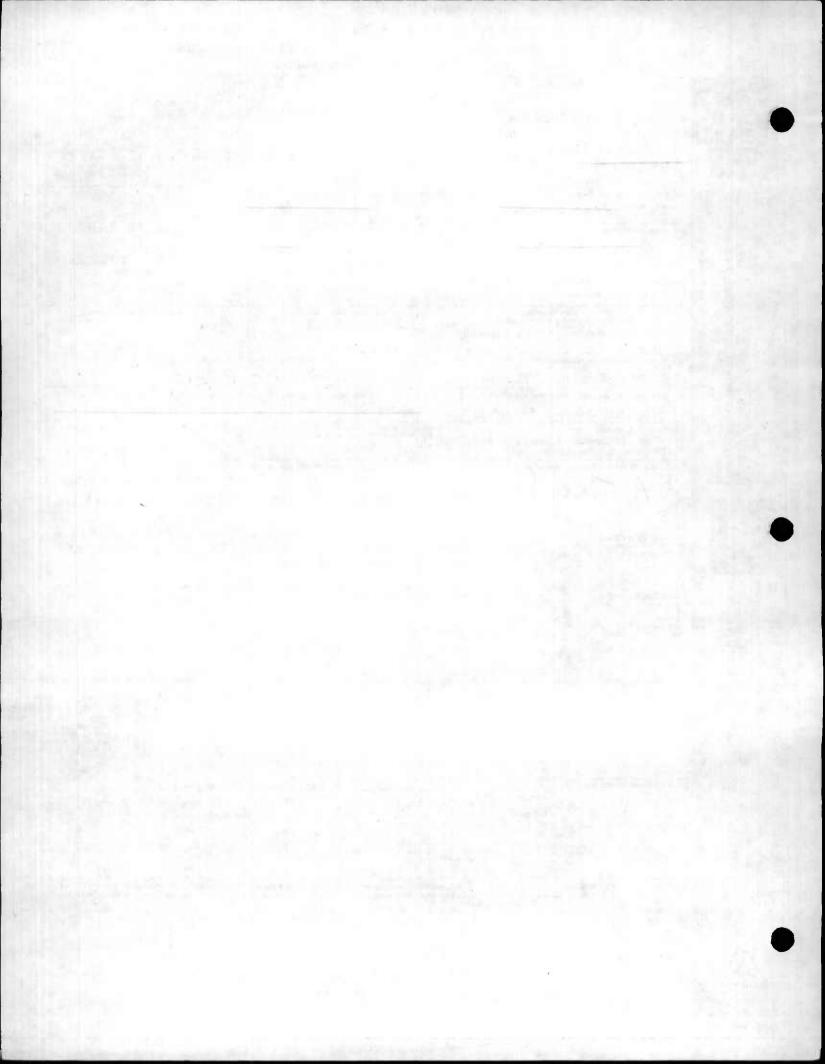


State of Maryland / Department of Health and Mental Hygiene \(\Omega\) AMENDED ITEMS 5,10b,c,e,f,19b PER INFORMANT G784 6/22/00 Aftertificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** JUNE 2000°° BESSIE G FRIDLEY 15 11:04am /Medical 4a Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Franklin Square Hospital Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. OCt. 12 1925 5. Social Security Number 7. Age (In yrs. last birthday). 74 Yrs. Birthplece (State or Foreign Country) **Funeral** 1□M 2KTF 200-04-0851 Usuei Residence of Decedent Director Maryland 10a. Stete 10b. County BALTIMORE 10c. City, Town or Location MIDDLE RIVER t0d. Inside City Limits MD Anne Arundel Glen Burnie 1 ☐ Yes 2 No Director 288-10e. Streat and Number 549 COMPASS ROAD 10f. Zip Code 10g. Citizen of What Country? 21220 natural, or hama 23a or 300 Lori Drive 21061 USA 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus filed within 72 hours after 1 Yes 20No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married 3altimore, Maryland 21215-0020 1 Yes 2000 Specify White Specify: 3 XWidowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker own home 8th 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be i Department of Health and Mental important; If them 27 is marked or George Albert Knott Anna May Firmwalt 19b Mailing Address (Street and Number of Rural Route Number City or Town, State, Zip Code)

4 Right Rudder Court Baltimore Md. 21220 19a. Informent's Neme/Reletionship (Type, Print) Henrietta Gibbs / daughter Baltimore Md. 21220 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 6 4 ☐ Donetion 5 ☐ Other (Specify) Holly Hill Cemetery 6/19/2000 Baltimore MD. 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Connelly Funeral Home of Essex 23a. Part. Enter the disease, or complications that caused the death period enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feiture. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Oronon Man 13. Examiner Due to (or es e consequence of) The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that Initiated events resulting in death) Lest and Due to (or as a consequence of) Box 68760. Physician/Medical the Due to (or as a consequence of): 88 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 3 Probably 4 Unknown signed I by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy parformed? page 2 i has 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA Certification: To 1 Inpatient this 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 1 Neturel 2 Accident 5 Pending n 24 hours after death.

e Funeral Director: After detely filled in by the fun investigation 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital edical Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29e. Certifler (Check only To the F Within 2 29b. Signature and #19 of certifie 29c. License number 29d. Date signed (Month, Dev. Year) PU me and add on who completed cause of death (Item 23a) (Type, Print) Suite 102 31. Date filed (Mor State 2000 Registrar **DHMH 16 Rev 6/95** 

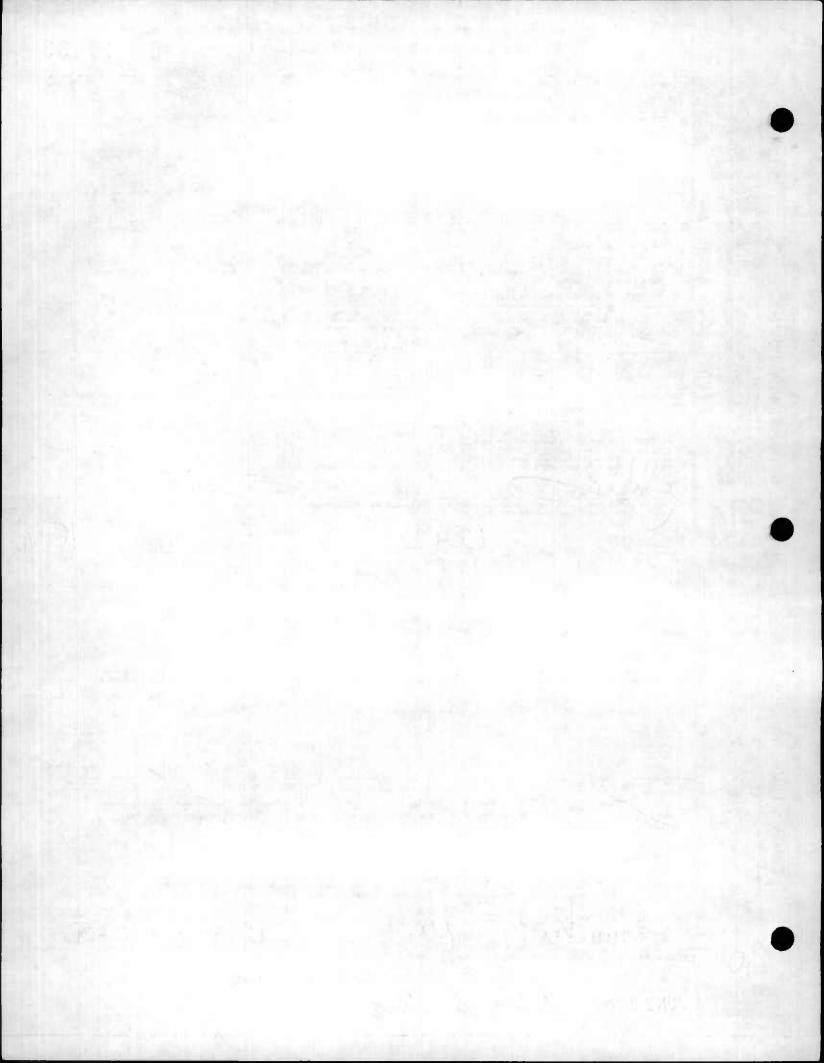


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State of Maryland / Department of Health and Mental Hygiene 1 1 2 1, 3 3

				Certificate of			Reg. No.		9433
Physician	1. Decedent's Name (First, Middle, Lamathie Akers (					2. Date of De Month	Day	Year	3. Time of Death
/Medical					4b. City, Town, or L	June	17, 2000		2:40pm
Examiner	4a Facility Name (If not institution, s 2012 Gracie Driv				Finksl	ourg	Can	roll	
Funeral Director	5. Social Security Number 226-22-7920	Sex 7. Age (7. Age (7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7	In yrs. last birth	Months Days		8. Date of Bir (Month, De May 19	th ly, Year) 9, 1923		ace (State or Foreig lry) ginia
D .	Usual Residence of Decedent  10a. Stete 10b. County	1	Oc. City, Town	or Location				140	Nel Incide City Limit
fanyle raho or	MD Carrol								od. Inside City Limit 1 ☐ Yes 2√ N
the h	10e. Street and Number		westi	ninster 10f. Zip Code			10g. Citizen of W	hat Count	
ifer death with the Ma r ferms 23s or 28s-f a sing result to mount Funeral Director	21 Washington	Lane Apt A		2115	7	T	J.S.A.	net Court	
by Fr.	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 2 No If Yes, Give Year or Dates:	er in U,S.	13. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☒ No		pecify Yes or No Pican, etc.)		- America k, White, a Whi	itc.
led within 72 ho tygiene. her then "neturn nt, the Medical I	15. Decedent's (Specify only highest (	Education (rade completed)	1	Decedent's Usual Occu Give kind of work done	dunna most of work	king	16b. Kind of Bus	siness/Ind	ustry
mpl.	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retin	ed)				
Spirit O	17. Father's Name (First, Middle, La	m41	1 De	partment N	1		Pantry P		
M of the	Charles Bruce Ak				The 1 ma	- //	, <i>Maiden Sum</i> ame	9)	
To To	19a. Informent's Neme/Relationship		1 400	14-70 4-44 (01				D4-4- 7'-	0-4-1
and 2 s alth an 27 is r er traur	Donna J. Redmon			Mailing Address (Streets Spruce Av					
T of He	20a. Method of Disposition	□Romaustinam State	20b. Place of I cemetery	Disposition (Name of crematory or other plants	ace)	Date	20c. Location - 6	City or To	wn, State
ment ment ment mury o	1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Ronation 5 ☐ Other (Spec	ify)	Baltimo	re Wash. C	rematory 6	5/20/00	Laurel,	Mary	land
Departr mportu any Inja	21. Signature of Futeral Strvice Lic	ensee	141	22. Name and Addr	ress of Facility LO1	ring Rye	rs Funer	al D	irectors
88 5 8 8	white s			8728 Liber	rty Road.	Randall	stown. M	D 21	133
	23 Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused th	e death. Do no						Approximate
Physician	Shock, pr (realt) allure. East on	y one cause on each line.	200					- 1	Interval Between Onset and Death
/Medical	Immediate Cause (Final disease or condition	( )	JY I					1	100
Examiner	resulting in deeth)	a. Du	e to (or as a co	nsequence of):					
je z	100.5							1	
rinicate be executed up physician and as the burial-transit Medical Examiner	Sequentially list conditions,	Du Du	e to (or as a co	nsequence of):				1	
olan i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury							1	
the b	that initiated events resulting in death) Last	Du Du	e to (or as a co	nsequence of):					
9 8		d							
d by the attending etached for use a Physician/M								t	
y the ched	Part II. Other significant conditions	contributing to death but n	not resulting in t	he underlying cause g	iven in Part I.				the cause of dear
y P						10	Yaa 2□ No	3 Prob	ably 4 Unknow
ins aw requires that this obsert ber to has been signed by the attending page 2 should be detached for usa completed by Physician/N						24a. Was	an autopsy ormed?	ava	re autopsy findings ilable prior to
10 N N								of d	npletion of cause leath?
nte ha						10	Yes 20 No	10	Yes 24No
yaichen: ine is certificate he director, page	25. Was case referred to medical axaminer?				26. Place of Dea	th (Check only	one)		
his ce il dire.	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outp	atient 3 DOA	ther: 4 Nursing H	ome 5 Resi	dence 6 □Othe	r (Specify	)
ter th neral	27. Manng-of Death 1 □Natural 5 □ Pending	28a. Date of fnjury (Month, Day Y	ear) 28b. Tir	ne of 28c. Injury	ury at ork?	28d. Describe	how Injury occurre	ed	
Attanding Physician: in death. ector: After this certific by the funeral director, iffication: To Be (	2 Accident investigati	on			Yes 2□No				
after death. Director: A I in by the fi	3 Suicide 6 Could not 4 Homicide determine			n, street, factory, office		28f. Location ( City or To	Street and Numbe	r or Rural	Route Number,
Ce iled is	/								
To the Hospital or Attanding Physical Within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors Medical Certification: To	(Check orly 2 Medical Ex	hydician: To the best of munician: On the basis of ex	amination and/	death occurred at the tor investigation, in my	ime, date and place, opinion, death occur	and due to the	cause(s) end mar date end place, a	ner as stand due to	ated. tha cause(s)
Wed mple	29b. Signature and title of certifier	and manner stated	1.	On time			004 Data signard	Marth F	a Vasal
5 ¥ 5 8	ANI CONTRACTOR	1.10	LIN	ZSC LIGHT	se number 2 ~ 2 a	9	29d. Date signed	(Month, L	( Tolar)
	Rundy	MW	10U)		DIDK	1	0-2	0 -	
00	30. Name and address of person wh	completed cause of deat	h (Item 23a) (T	ype, Print)	3 (3 x)		1		_
	1-19010 Scuter N	1.1). <1 Cros	ssroad	SILrive	415 Ow.	ngs Mu	15 MD	211	7
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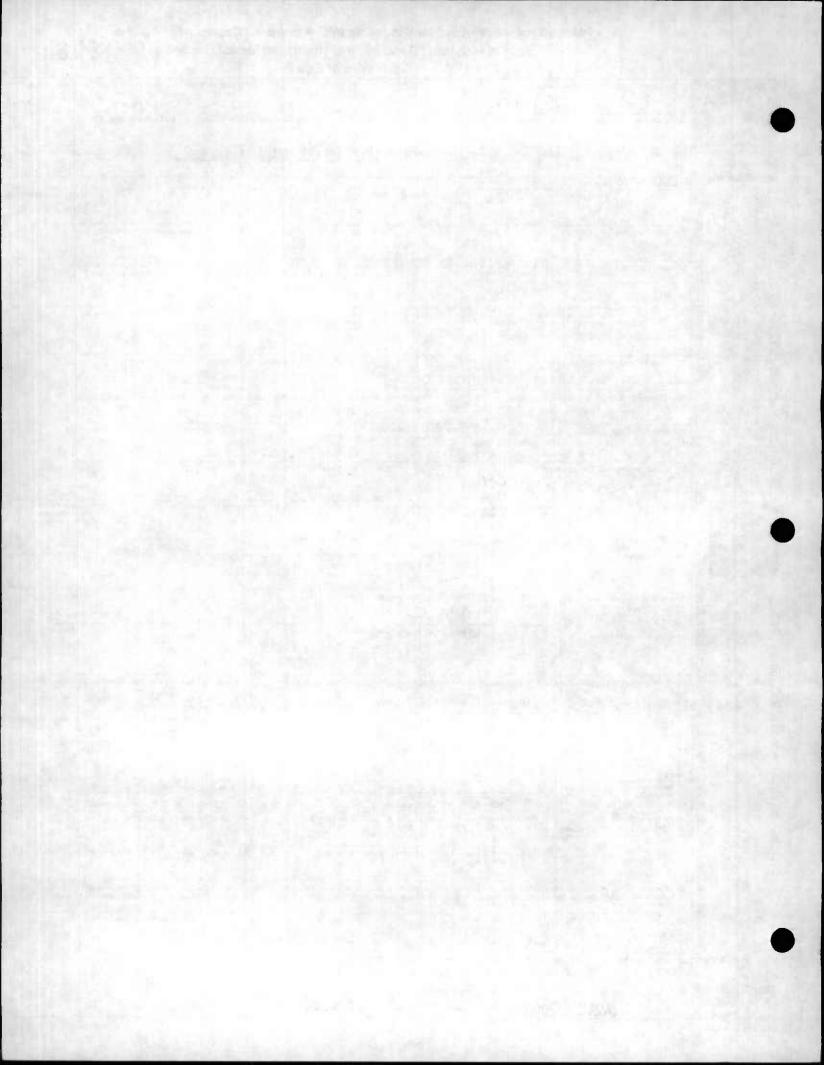
State of Maryland / Department of Health and Mental Hygiene

19434

					tificate of	Dodin			Reg. No.		
ician	Decedent's Name (First, Middla,							2. Data of De Month	Day	Year	3. Tima of Death
dical		Grove						June		2000	3:43 1
niner	John Hopkins Bay	-	um <i>ber)</i>		10.55			ocation of Deat	h 4c. Coun	ty of Death	
		6. Sex	7. Aga (In yrs.	last histhelast	If Under 1 Yaa		tim		at.	N/A	
al or	218-88-6121	1 □ M 2X F	3		Months Day		Min.	8. Date of Bir (Month, Da NOV 9,	1962	Mary	lace (Stata or Forei (Inc.) / Land
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cto	Maryland Balt	imore			Balti	more					1 □ Yes 2 汉 h
Il Director	10e. Street and Number 7918 Eastdal	e Road			10f. Zip Code 2	1224			10g. Citizen of	What Coun	itry?
Funeral	11. Maritel Stetua		cedent Evar in U	J,S. 13. V	Was Decedent of f Yes, specify Cu	Hispanic Or	gin? (Sp	acify Yas or No	)- 14. Ra	ce - Amaric	
by Fu	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed F d 1 Tes If Yes, G Year or I	2 1 No liva		T Yes, specify Cu		i, rueno	Hican, etc.)		ack, White, by: Whi	
	15. Decedent's		Datas.	16a Deced	tent's Usual Occi	unation			16b. Kind of I	Business/Inc	fustry
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o Be Completed	17. Father's Name (First, Middla, L	est)		SELVE		18. Moth	ar's Name	a (First, Middle	, Maidan Suma	ma)	
OF	William McCla	ir Gam	mons			Wil	Lma	Jean 1	Peyton		
	19a. Informant's Name/Ralationsh				ng Address (Stree						
	Wilma Jean Ga	ydos/Mo	other	228 k	Kingsto	n Roa	ad B	altimo	ore, M	D 212	220
	20a. Mathod of Disposition 1 □ Burial 2 □ Cremetion	n Chamaral from		Place of Disportant Comptens, crem	sition (Neme of natory or other p	lece)		Data	20c. Location	- City or To	wn, Stata
	4 Donation 5 Other (Spi			tro Cr	emator	y, Ir	nc. 6	/17/00	Balt	imore	e, MD
	21. Signeture of Funeral Service Li	11 1	11	22	Nama and Add ematic	rass of Facili	ty.	v of I	MD In	C	
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dica	that initiated evants rasulting in death) Lest	C	Dua to (c	or as a consequ	uence of):				1		
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0	axaminer? 1 ☐ Yes 2 No	Hospital:	Inpatiant 2	ER/Outpatien	1 3 DOA	ther:		h (Chack only	idance 6 □O	ther (Specif	iv)
-	27. Manner of Death	28a. Data	of Injury	28b. Tima of	28c. Inj				how injury occi		y)
it io	1 Natural 5 Pending 2 Accident invastiga	,	nth, Day Year)	Injury		ork? ⊒Yas 2□	No				
Hice	3 ☐ Suicida 6 ☐ Could no	208. Plac	e of Injury - At h	oma, farm, stre	eet, factory, office	В		28f. Location (	Street and Nun	ber or Rura	I Routa Number,
- P	4 Homicida	Duild	ting, etc. (Speci	(y)				City or To	wn, Steta)		
Medical Certification: To Be Completed by Physicia	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the	a best of my kno besis of axamine nnar stated.	owledge, daath etion and/or Inv	occurred at tha astigation, in my	tima, data an	d place, th occur	and dua to tha red at the time,	causa(s) and r deta and plece	nannar as si	tated. the cause(s)
M	29b. Signetura and titla of certifiar	and mai	miai stateu.		29c. Licar	nsa number			29d. Data sign	ed (Month,	Day, Year)
		plu (	2			5 00	0		June		
		and 1	//		NC.		0		June	17,	2000
			17777		- 1 - 1						
	30. Name and address of person w	ho completed ceu									
ate		ho completed ceu	ise of death (tter 닉역닉 이 Registrar's Signa	Easte	Print) Sn Aven	·e					

**ORIGINAL** 

DHMH 16 Rev 6/95



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month William Frank Gayo June 16, 2000 4:06 PM 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Mariner Health of Glen Burnie Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 100 M 2□ F Yes 218-03-5388 Usuat Residence of Decedent Pennsylvania MAR 18. 1916 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Linthicum 1 ☐ Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 815 Oregon Avenue 21090 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: WWII 14. Rece - American Indien, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □ Never Married 2 □ Merried 1 ☐ Yes 2 No Specify: Specify: White 3 DWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Auto Mechanic Auto Repair 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Frank Gavo Anna Krebs 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 114 Glendale Avenue Glen Burnie, MD 21061 Miriam Donovan/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/17/00 Baltimore, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Cremation Society of MD, Inc. Edward A. Gregorchik 299 Frederick Road Balt 23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart leiture. List only one cause on each line. Baltimore. MD 21228 Approximate Intervel Between Onset and Deeth CORONARY Immediate Cause (Finel disease or condition resulting in death) TENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury HRONIC OBSTRUCTIVE PULMONARY that initiated events resulting in death) Last Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2□No 3 Probably 4 Unknown 01 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 X No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

or herns 23s or 28s-f shorements of sections of sectin

permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hyglans. Important: if itam 27 is marked other than "natural", or items 23a or 2 and Pilytry or other traumatic avant, the Medical Examination page.

Baitimore, Maryland 21215-0020

NILLIAM

Director

Funeral

Be Completed

the Manyland

attending physician and for use as the buriel-transit The law requires that the death certificate be executed P.O. Box 68760. paga 2 should be Deen certificate has director, this

funeral After

Physician/Medical Examiner Records. P Be Completed Division of Vital Attanding Physician: Certification: To To the Hospital or Attanding within 24 hours after death.
To the Funeral Diractor: Afte completely filled in by the fun

State Registrar

Medical 29b. Signatu

29a, Certifier

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 ☐ Homicide

5 Pending investigation

6 Could not be determined

ress of person who complete

M. B. S. J. B. T. A. P. LTCHE HIGHWAY, BALTIMORE,

M-D

28a. Dete of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

MARYLANDoaks

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

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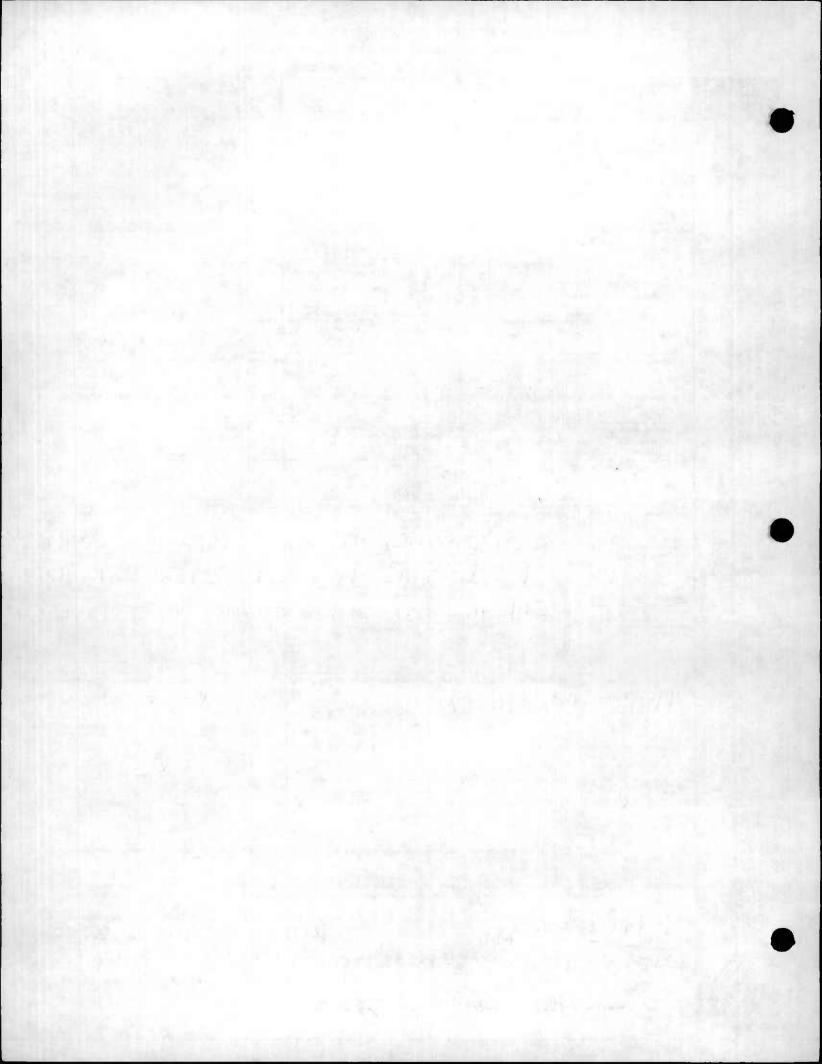
28d. Describe how injury occurred

Location (Street end Number or Rurel Route Number, City or Town, State)

29d. Date signed (Month, Dey. Year)

JUNE 16, 2000

31. Date fited (Month, Day, Year) 32. Registrar's Signeture 2000



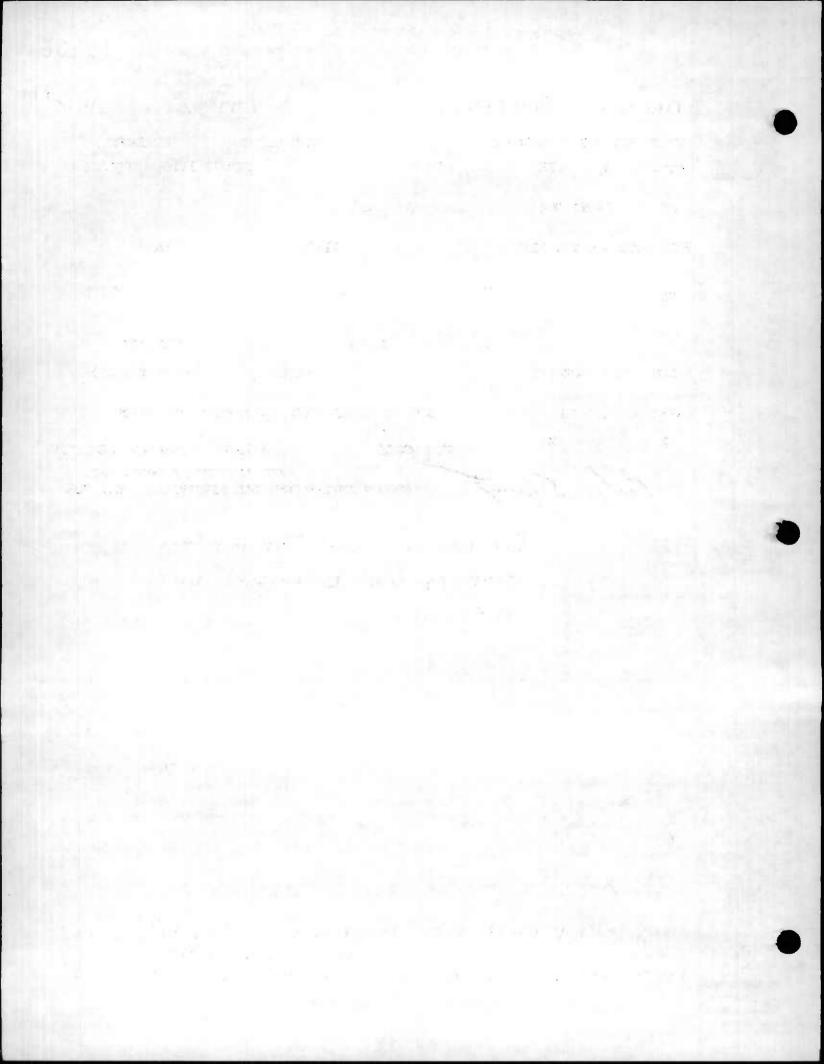
					Certificate of	Death		Reg. No.		
Physici	an	1. Decedent's Neme (First, Middle, La	ast)		7 1		2. Date of De		3. T	Time of Deeth
/Medic		PARON	GORBAT	1		JUN	E 17th	2000	. 1001	,15 Am
Examin	er	4a. Fecility Neme (If not institution, gir	ve street end number)			4b. City, Town, or L	ocation of Deet	4c. County	of Deeth	
		NORTHWEST HOSPIT		yrs. last birtho	day) If Under 1 Yee	RANDALLST r if Under 24 Hrs.	OWN 8. Dete of Birt	BALTI		(Ctata as Fassian
Funeral Director			M 2□ F	84 Yr	Months Devs		FEB 12	1916	POLAND	State or Foreign
Sa-f show tiffed at	ctor	MD 10b. County BALTIMO		c. City, Town o	r Location PIMORE		te			side City Limits  ☐ Yes 2X No
23a or 26	al Director	10e. Street end Number 7920 SCOTTS LEVEL	ROAD		10f. Zip Code 2.	1208		10g. Citizen of V USA	Whet Country?	
iene. r than "natural", or items 23e or 28e-f ehow the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  XXWidowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes ANO If Yes, Give Yeer or Dates:	in U,S.	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No	ben, Mexicen, Puerto	ecify Yes <i>o</i> r No Rican, etc.)		ce - American Ind ck, White, etc. V: WHITE	
natu	Completed	15. Decedent's E (Specify only highest gr	ducetion ade com <i>pleted)</i>	10	ecedent's Usuel Occu	e during most of work	ing	16b. Kind of B	usiness/Industry	
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t t t	e Co	17. Fether's Neme (First, Middle, Last			RADDI	18. Mother's Nem	e (First, Middle,			
0 0	0 8	ARYEH LEB GORBA				MERKE		UNOBTAI		
EE		19a. Informent's Name/Reletionship (	(Type, Print)	19b. N	Mailing Address (Stree	et end Number or Rur	el Route Numbe	er, City or Town,	Stete, Zip Code	)
- CV -		MAYER GORBATY/SON		3300	MIDFIELD	ROAD BAI	TIMORE,	MD. 21	.208	
		20a. Method of Disposition 1   Burlai 2 □ Cremetion 3   4 □ Donetion 5 □ Other (Speci	Removel from State			6/	Dete /19/00		City or Town, Si	
Important: If i any injury or once.		21. Signeture of Funeral Service Lice	change !		22. Name end Add			ON & BRO		08
edical es the bunal-transit es the bunal-transit	i Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury	b. OROPH	ARYN to (or es e cor	GEAL . T			WITH		
gned by the attending physic be detached for use as the b	Physician/Medical	thet initiated events resulting in deeth) Lest  Pert II. Other significant conditions of	d.	to (or es e con	sequence of):	iven in Pert I.		obacco uea co Yes 2 □ No	ntribute to the c	ause of death?
been signer should be d	by							en eutopsy	24b. Were au	topsy findings
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ate h	9	25. Was case referred to medical examiner?				26. Place of Deet	h (Check only o	ne)		
ctor, page	m	GAGIIII GI I	Hospital: 126 Inpatient	2 ☐ ER/Outpa	Itlent 3LI DOA		me 5 Resid	dence 8 🗆 Oth	er (Specify)	
dire	To Be	1 ☐ Yes 2 No			a of 20a Init	une of	28d. Describe I	now Injury occur	red	
₩ ₩	ToB	27. Menner of Death Naturel 5 Pending investigation	28a. Dete of Injury (Month, Day Yean	ar) 28b. Tim Inju	ry Wo	ork? Yes 2 No				
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пет deatn. Irector: Affer th n by the funeral	edical Certification: To B	27. Menner of Death   Naturel   5   Pending investigation   3   Suicide   4   Homloide   Could not be determined	28a. Dete of Injury (Month, Day Ye  28e. Piece of Injury - building, etc. (S)  yalclan: To the best of my niner: On the basis of exa end menner stated.	At home, ferm pecify)  v knowledge, d mination end/o	M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ime, date end plece, opinion, death occurr	28f. Location (so City or Tover and due to the end of the time,	ceuse(s) and madete end plece,	enner as stated. end due to the co d (Month, Dey, Y	ause(s)  /eer)

Sporks

DHMH 16 Rev 6/95

State

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth JUNE Yee 8:55 qu **Physician** ROSE GARTNER 16,2000 /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** NORTHWEST HOSPITAL CENTER BALTIMORE RANDALLSTOWN 5. Sociel Security Number 212–40–5420 If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dev. APR 10 Birthplece (State or Foreign Country)
 MD 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 93 Yrs. Months Deys Hours Min 1 □ M 2 🕅 F Director Usual Residence of Decedent with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylei Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23e or 28e-f ehow any injury or other traumatic event, the Medical Examiner must be united at once. 1 ☐ Yes 2 ☐ No Directo BALTIMORE PIKESVILLE MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1500 BEDFORD ROAD APT.219 21208 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Status 1 Never Married 2 Merried Specify:WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 3√ Widowed 4 □ Divorced ð Yeer or Dates 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER LONDON FOG CO. 18 Mother's Name (First Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be JULIUS BESSIE SHANNON DAVIS 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) HARRIET B.HALPERN/DAUGHTER 8229 STREAMWOOD DRIVE BALTIMORE, MD. 21208 20e. Method of Disposition 20b. Plece of Disposition (Neme of 20c. Location - City or Town, State ARLINGTON—CHIZUK AMUNO XXBurial 2 Cremetion 3 Removal from Stete 6/18/00 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) CONGREGATION 22. Name end Address of Fecility 21. Signeture of Funeral Service Licensee SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** Respusing Faceurs /Medical Immediate Cause (Finel disease or condition resulting In deeth) Examiner Due to (or es e consequence of): Physician/Medical Examiner There wie The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest attending physician and for use as the buriel-tran Due to (or es a consequence of) Box 68760, Due to (or as e consequence of) signed by the a Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were eutopsy findings avellable prior to completion of ceuse of death? 2 should 24e. Wes en eutopsy Completed performed' page 2000 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was cese referred to predicel examiner? director Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 INO 1 patient 2 ER/Outpatient 3 DOA this 27. Menmer of Deeth Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: Affer Natural 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, efc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) à 4 Homicide To the Hospital or within 24 hours eft To the Funeral Discompletely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. edicai 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of bertif DUN 505 MIN JUNE

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

IMPERIA

m) - NWHE

State Registrar 30. Name and addre

31. Dete filed (Month

Dey, Year)

DHMH 16 Rev 6/95

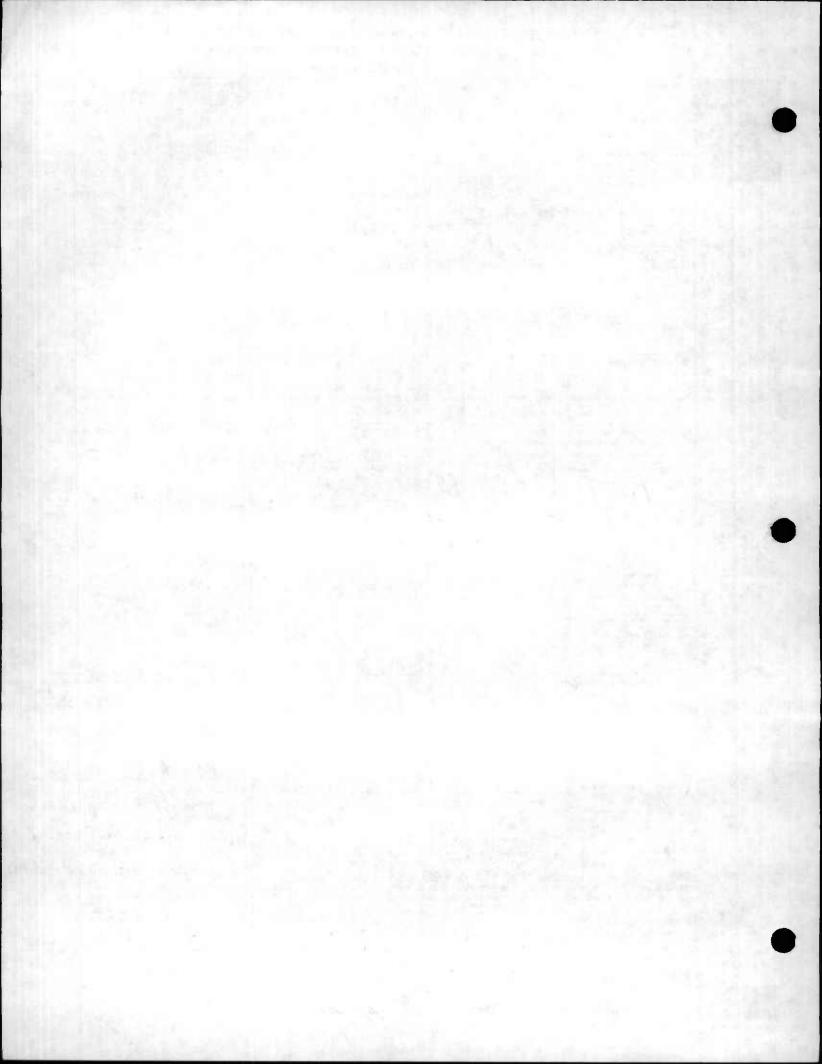
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Year Month **Physician** TERT LOH 1440 PM GREEN 2000 June 16 /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** 8655 Pulaski Highway White MArsh Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Feb. 2 194 5. Social Security Number Birthplece (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Deys Months 1□M 21 F 1949 215-52-6520 51 Yrs. Feb. Director Washington Usual Residence of Dacedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD HArford Director Aberdeen terns 23s or 28s-f must be notif 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3402 Crosswood Road Funeral 21001 USA Wes Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? be fied within 72 hours after dea tal Hygiene. d other than "natural", or Itams event, the Medical Examiner m 1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Detes: Never Merried 2 ☐ Married Maryland 21215-0020 1 Yes 2010 Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Laborer CSX Railroad 12th 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumema) Be Mental is marked Marvin Green Avonne Arlene Parker should To 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m David Wilson / friend 3402 Crosswood Road Aberdeen MD 21001 Baltimore, 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stata Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Metro Crematory Inc. 6/19/2000 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore MD 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex 23e. Pert1. Enter the disease, or complications that caused the death popular inter the mode of dying, such as cardiac or respiratory errest, shock, or heart tellure. List only the cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel 10 5 minutes wound disease or condition resulting in deeth) Examiner Due to (or es e consequenca ot) Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequenca of): Box 68760 physician Physician/Medical the Dua to (or as a consequence of): 950 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by of Vitai Records. 24a. Was an eutopsy performed? 24b. Were eutopsy tindings aveileble prior to Completed completion of causa of death? has 1□ Yes 2 No 20 No certificate 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence State (Specify) PARKing Lot Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 15 Yes 2□ No Medical Certification: To this funeral 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? After Attending Division ours after deah. 5 Pending investigation 1 Natural June 16,2000 1425 PMM 1 Yes 2 No Selfinflicted Gun Shotwoun 2 ☐ Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 86.55 Pulaski Highway, Whitakerh MD 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Parking lot To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Dey, Year) June, 17, 2000 Deput 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) 0 > Milite PHILI MD Greene Himore, 10 225. 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State JUN 2 0 2000 Registrar DHMH 16 Ray 6/95

**ORIGINAL** 



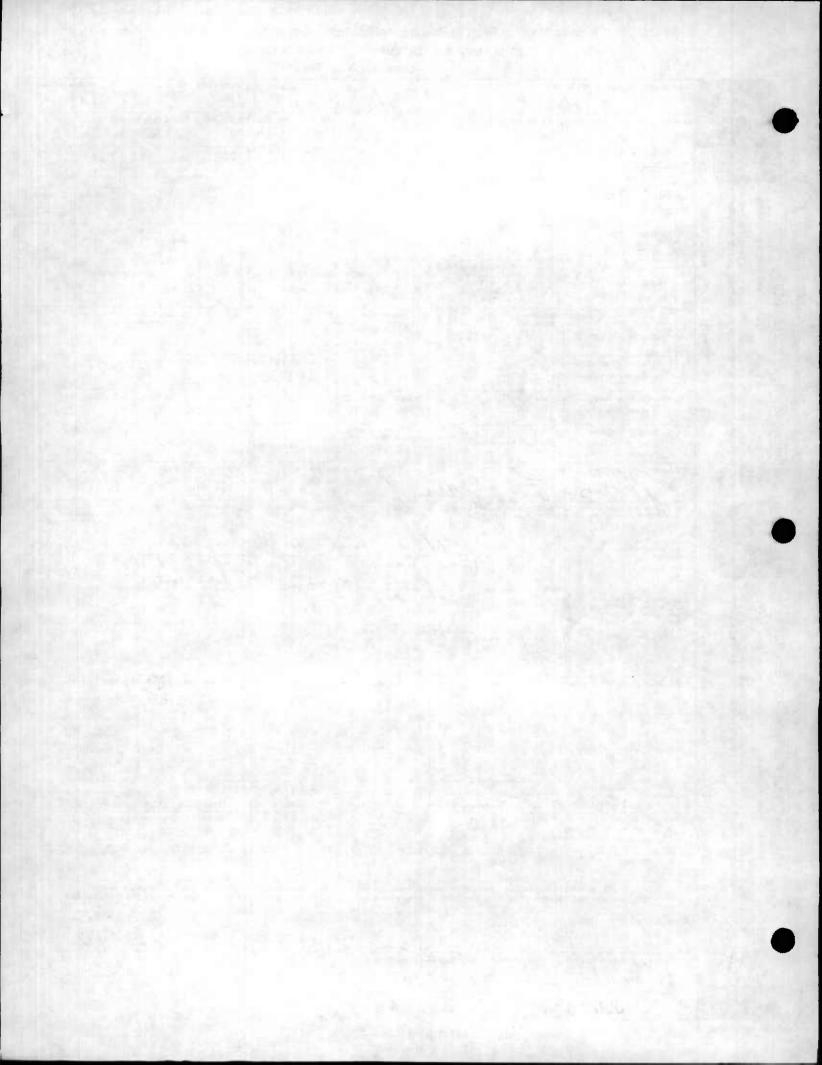
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State of Maryland / Department of Health and Mental Hygiene

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			Cen	tificate of	Death		Reg. No.	12402
hysician	1. Decedent's Name (First, Middle, Las	Bernar	of 1	Hihr	. Jr.	2. Date of Dea Month June	ath _	3. Time of Deeth 4:25 A.M.
/Medical Examiner	4a Facility Name (If not Institution, give Edenwald Retirement Co			2.24.5.1	4b. City, Town, or L Baltimon	e	Ba1t	cimore Co.
neral rector	215 10 0000	9X M 2□ F 7, Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt Month, Da December	13,1921	9. Birthplace (State or Foreign Battimore, Maryland
ner must be notified at	Usual Residence of Decedent  10a. Stete 10b. County  Maryland Baltir		y. Town or Loc altimore	ation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
at be notified	10e. Street and Number 800 Southerly Road un	nit1515		10f. Zip Code 2	21286		10g. Citizan of W United St	hat Country? ates of America
Examiner must by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 △ Yes 2 ☐ No If Yes, Giva Yaar or Dales:		/as Decedent of I Yes, specify Cub □ Yes 2 No	Hispanic Origin? (Spen, Mexican, Puarto Specify:	pecify Yes or No- Rican, etc.)	14. Raca Black Specify:	- American Indian, K, White, atc. White
pleted	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Decede (Give k life. D	ent's Usual Occur and of work dona O NOT use ratire	pation during most of work	king	16b. Kind of Bus Telecomm	siness/Industry unications/
Complet	Elementary/Secondary (0-12)	College (1-4or 5+) n/a		Installer	1			ephone Company
To Be	17. Father's Nama (First, Middla, Last) John Bernard Hihn, Sr				Mary Helen		Maiden Sumeme	)
	19a. Informant's Neme/Relationship (7 Mrs. Martha Noinette I	Hihn(nee Diehl)	800 Soc	utherly Ro	and Number or Ru ad unit15		or, City or Town, S More, Mary	
	20a. Method of Disposition  1  Buriel 2  Coremetion 3  4  Donetion 5  Othar (Specify	Removal from State	ematary, crem	ition (Neme of etory or other ple vice Corpo		Date /20/2000		City or Town, State  1, Maryland
DUCE	21. Signature of Fundal Service Licens	see Deffrey L Ga	ir 22.	Name and Addre			Funeral Ho L. Towson,	ome, Inc. , Md. 21204
ın	23a Part Enter the disease or comp	plications that code of the death	n. Do not ente	r the mode of dy	ing, such as cardiac	or respiretory a	rest,	Approximata Intervat Between Onset and Death
	Immediate Cause (Final disaase or condition rasulting In death)	pt	Vevi	n oria	, with	enp	yeun	2nks
ner		Que to (or	p a consequ	lence of):	yan s	drs	iane	2903
Medical Examine	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last	c	as a consequ					
Physician/	Part ti. Other algnificant conditions co	entributing to death but not resu	ulting In the un	derlying cause gi	iven in Part I.	23b. Dld	obacco usa con	tribute to the cause of death?
by Phy						10	Yaa 2 No	3 Probably 4 Unknown
Completed b							an autopsy rmed?	24b. Wera eutopsy findings evailable prior to completion of cause of death?
Com						10	res 21 No	1 Yes 2 No
o Be	25. Was case referred to medical examiner?	Hospital: 1 tnpatient 2	FR/Outpatient	3□ DOA Ot	26. Place of Dea		me) denca 6 □Otha	u (Specify)
ation: T	27. Manner of Death  1. Natural 5 Pending 2 Accident Invastigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. tnju			now injury occurre	
Certification:	3 Suicide 6 Could not be 4 Homtcide determined	28e. Place of Injury - At ho building, atc. (Specify	oma, farm, stra	at, factory, office		28f. Location (: City or Tox	Street and Number vn, Stete)	er or Rural Route Number,
edicai (	29a. Certifiar (Check only one)	rsician: To the best of my know iner: On tha besis of examinat end manner stated.	wledge, death tion and/or inv	occurred at the trastigation, in my	ime, data and ptaca opinton, daath occu	, and dua to tha rred at the time,	cause(s) and mar date and placa, a	nner es stated. nd dua to the cause(s)
Me	29b. Signature end titla of certifier	1	/	29c. Licen	se number		29d. Date signed	(Month, Day, Year)
	30. Name and address of person who o	completed cause of death (Item	23a) (Type F	Print)	2976	9	6/	1910
1	morrelino	D. Alm	erme	5	16 a.	Rolli.	y Rd	Bu 14 21278
State   egistrar	31. Date fited (Month, Dey, Year)  JUN 2 0 2	32. Registrar's Signat	ture 4	1		6	7	

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 0 0 1 9 4 4 0

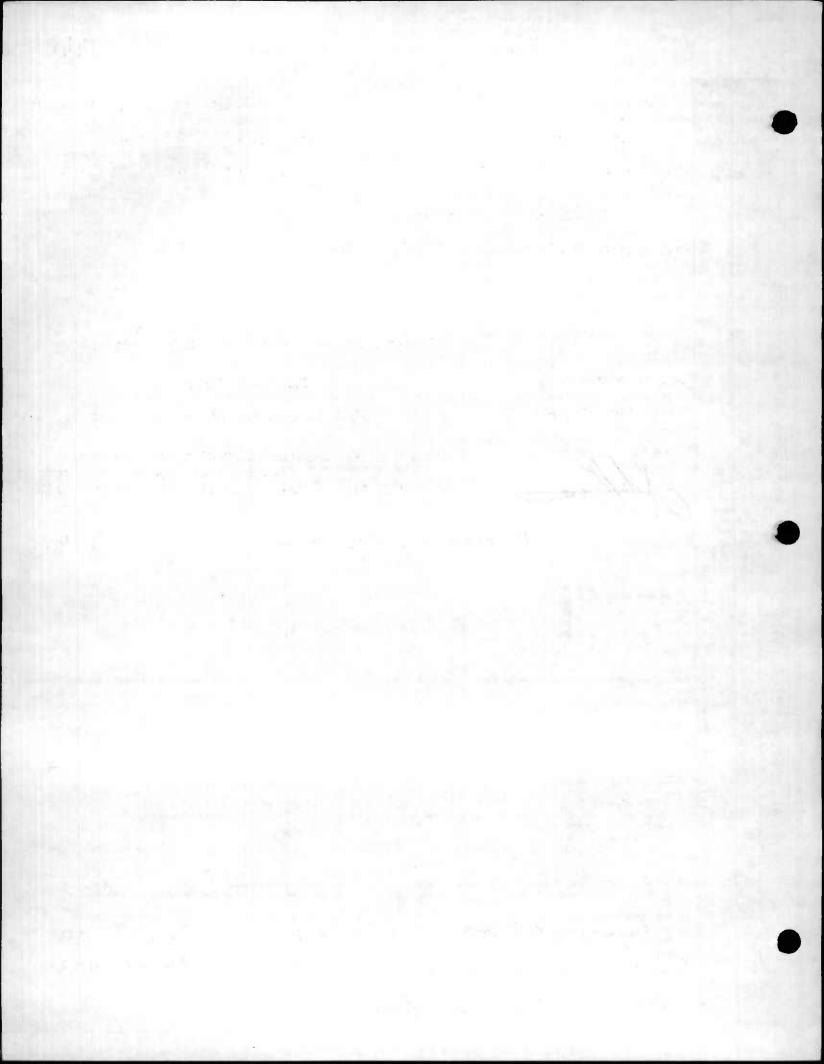
Certificate of Death

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Exami	iner	4e. Fecility Neme (If not institution, gi					4b. City, Town	n, or Location of De	eth 4c. Count	ty of Deeth	
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yland		10a. Steta 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
Mar	io	MD Baltimo	re	Rock	dale						1 ☐ Yes 2 ☐ No
with the	Director	10e. Street end Number	1 4 4 05			10f. Zip Code			10g. Citizen of	Whet Cou	ntry?
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72 hours after death with the Maryland "natural", or items 23s or 28s-f show potcal Examiner must be not lived at	by Funeral	1 □ Navar Married 2 💢 Married 3 □ Widowed 4 □ Divorced	Armad Forces?  1 ☐ Yes 2 ☐ N  If Yes, Give  Year or Detes:		11	i Yes, specify Cu	iban, Mexican, I	n? (Specify Yes or Puarto Rican, etc.)		ice - Americack, White,	etc.
d within 72 ho plane. r than "natur the Medical	Completed	15. Decedent's E (Specify only highest gr	ducation		16e. Deced	lent's Usuel Occ kind of work don	upetion	f working	16b. Kind of I	Business/In	dustry
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		4 □ Donetion 5 □ Other (Speci	•	Balt	imore	Wash.	Cremato	ry 6/20/0	0_Laurel	,_Mar	yland
Depart Import any inj		21. Signature of Fureral Agrace Lice	nsee		87	. Name end Add	ress of Fecility ]	Loring By d, Randal	ers Fune	ral I Maryl	irectors I and 21133
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the character	Physician	Part II. Other eignificant conditions of	contributing to deeth bu	it not resulti	ng in the ur	nderlying cause of	given in Pert I.	23b. Di	d tobacco use c	ontribute to	the causs of death?
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^		30. Neme end eddress of person who	completed cause of de	eth (Item 2	3e) (Type I	Print)					
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	and the last	21 Date filed (Mark Co., Vo.)			M Cali						

DHMH 16 Rev 6/95

Registrar

JUN 2 0 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** MARY O. HAZLE 6:50 pm 15 2000 June /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Square Hospital Center hosedale If Under 1 Year If Under 24 Hra. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Hours Yrs. 212-82-9400 Director Sept. 4. 1916 Alabama **Usual Residence ot Decedent** 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Heelth and Mentel Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any fujury or other traumatic event, the Medical Examiner must be notified at page. Baltimore Baltimore County/Perry Hall 1 Yes 2 No Director Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21128 USA B927 Cowenton Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forcea? 1 ☐ Yes 2 Ø No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 Ø Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 8 Yrs. College (1-4or 5+) N/A Housewife Homemaking-Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Dossie Columbus Perryman Curlis Lee Carter 19e. Informant'a Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Wayne Hazle 8927 Cowenton Avenue Perry Hall, Md. 21128 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel trom Stete 4 Donetion 5 Other (Specify) Holly Hill Cemetery 6-19-2000 Baltimore, Md. 22. Name and Address of Facility
Lassahn Funeral Home 21. Signeture of Fugeral Service Licensee Hass chard 7401 Belair Rd. Baltimore, Md. 21236 23a. Pert1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Gastric Cance Examiner Examiner attending physicien end for use es the burlel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events reaulting in death) Last Due to (or es a consequence of): P.O. Box 68760, Physician/Medical Due to (or ea e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records, by 24b. Were autopsy lindings available prior to Completed 24a. Was en autopsy performed? completion of cause of death? this certificate has 2 K No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartiflot completely filled in by the funeral director, 25. Was case reterred to medical 8 26. Place of Deeth (Check only one) Hospitel: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 27. Menner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, term, street, lectory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stele) 4 ☐ Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner a stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) June 15,2000 arow My

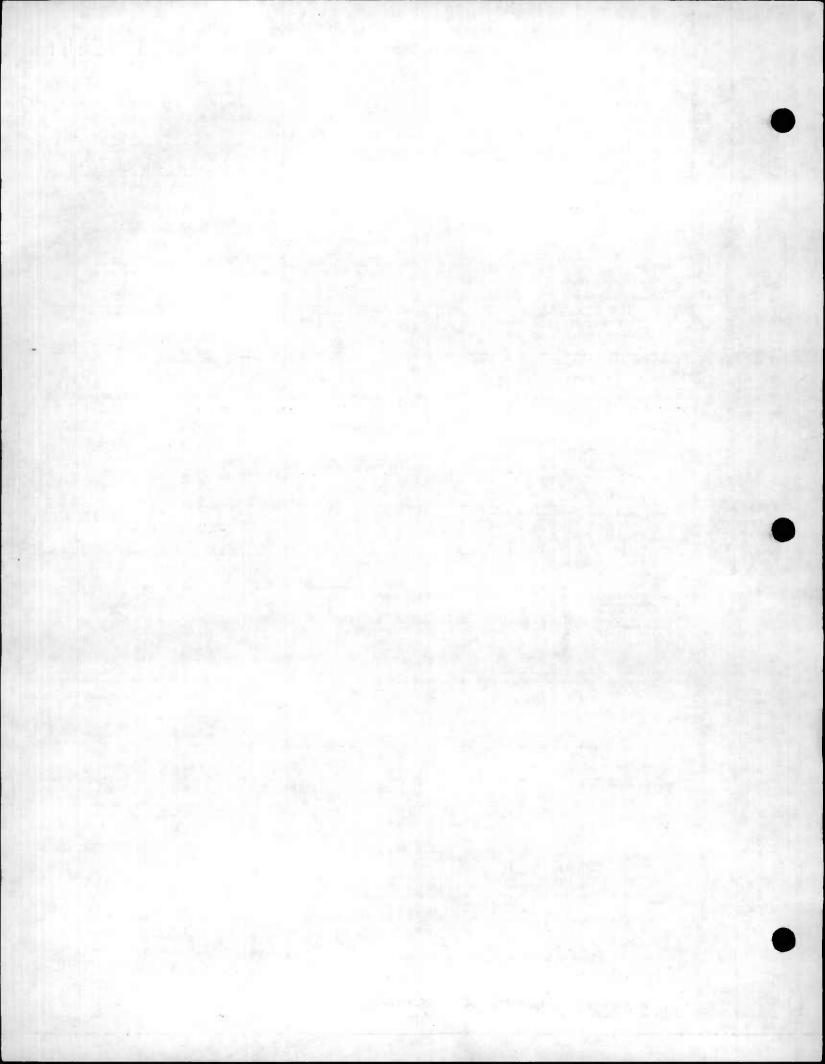
State Registrar **DHMH 16 Rev 6/95** 

30. Name and address of person w

31. Date tiled (Month, Day, Year,

DRMARCO ZAMORA 9000 Franklin Square Drive Baltimore MD 21237 32. Registrar's Signeture

completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5:30 AM 2000 GERTRUDE PAULINE HUESMAN 4c. County of Death 4a Fscility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death Belair Harford 908 Lakeside Terrace If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 27, 1911 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Days 10 M 20X 220-05-7938 89 Yrs. Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Belair/Harford County Harford 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 908 Lakeside Terrace 21014 USA 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3)(Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ng most of working Elementary/Secondary (0-12) College (1-4or 5+) Grue Tailoring 8 yrs. Tailor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilhelmina Volmer Frank Nollmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 Lakeside Terrace Belair, Md. 21014 Mrs. Mary L. Gostomski 20b. Ptaca of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dulaney Valley Cemetery 6/5/2000 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087 Approximate tritervat Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. moute Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

physician end s the bunal-transit

98 981

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certificate

After this

To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

id other than "natural", or flams 23s or 28s-1 show avant, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death a Department of Health and Mentel Hygiene. Important: if than 27 is marked other than "natural", or thems 23a any injury or other traumatic avant.

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Examiner Physician/Medical 2 Completed Be To Medical Certification:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No

	Wes case refer	ed to medical				26.	Place of D	eath (Check only one)
	examiner? 1 Yes 2 4	10	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□	DOA Other: 4	Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
	Manner of Death 1 PNatural 2 Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work?	2 □ No	28d. Describe how injury occurred
	3 Suicide 4 Homicide	6 Could not be determined	28e. Placa of Injury - At h building, etc. (Speci	nome, ferm, streety)	t, fact	ory, offica		28f. Location (Street and Number or Rurel Route Number, City or Town, State)
296								ca, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)

, mind	77701111
29b. Signature and title of certifies	
Wait 6th	1

29c. License number

29d. Date signed (Month, Day, Year)

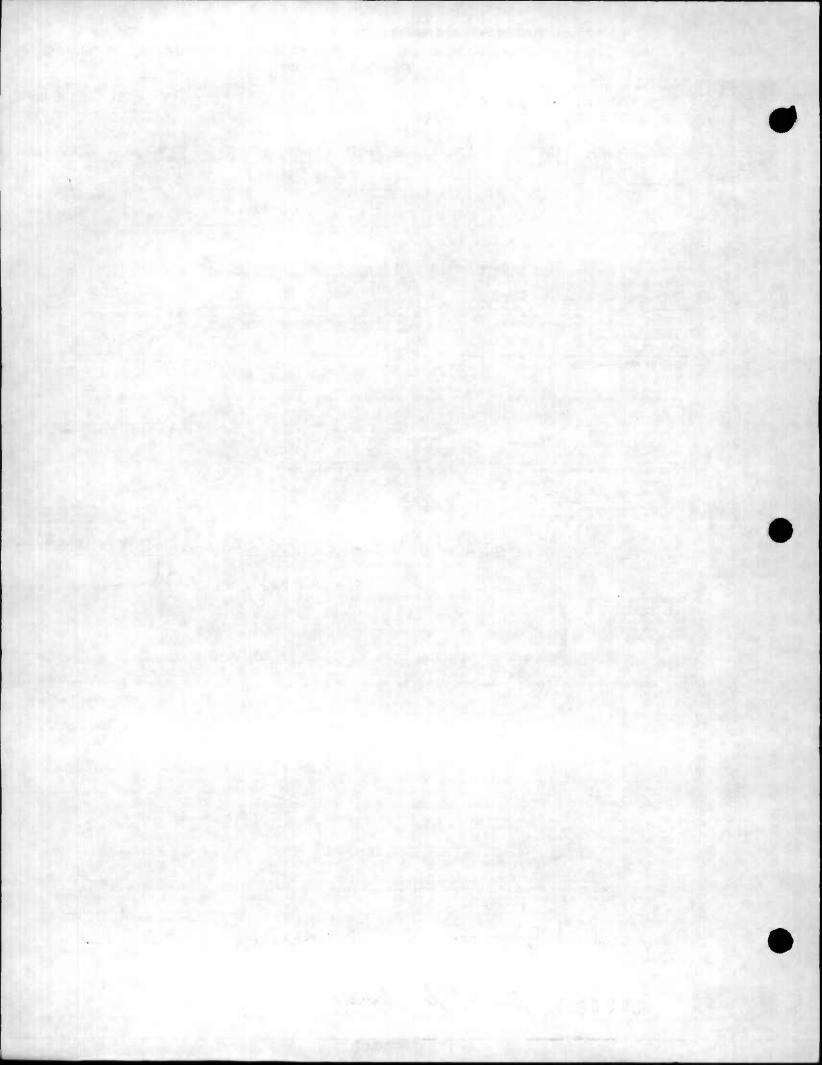
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Robert Duncan M.D. 615 W. Mcphail Rd Belair, MD21414

31. Date filed (Month, Day, Year) JUN 2 0 2000 32. Registrar's Signatura

Registrar **DHMH 16 Rev 6/95** 

State



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] AMEND ITEM: #16B PER F.H. G784 6-20-00 WR. Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** JOHNSON JAMES 5.19 pm JUNE 15 2000 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HARBOR KOSPITAL BALTIMORE CENTER M Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F Months Days Yrs. Director 217-40-6464 57 25 M.D Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiens.
7 is marked other than "natural", or heme 23s or 28s-4 show traumatic avant, the Medical Examples must be notified as 1X Yas 2□No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 Cherry Hill Road 21225 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1)∑ Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 ☐ Merried 1 Yes XXNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry UNK Elementery/Secondary (0-12) College (1-4or 5+) Disabled 12th grade 3 yrs Disabled permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: If Nam 27 is marked other any Injury or other traumatic avent, DRSs. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Jasper Johnson Sr. Eunice Rush 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eunice E. Johnson-Mother 1001 Cherry Hill Road, Baltimore Md 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) Crematory Inc. 6/20/2000 Baltimore, Md Metro 21. Signature of Funeral Service License 22. Name end Address of Facility March F/H West Mark 4300 Wabash Ave, Baltimore Md 21215 23a. PertY. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete tntervel Between Onset end Deeth Physician Immediate Causa (Finel disease or condition resulting in death) /Medical A DULT RESPIRATORY DISTRESS SYNDROME 5 DAYS Examiner Due to (or as a consequence of): Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pul physician is the burie Physician/Medical Due to (or as e consequence of): USE AS Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by d be dated 1 Yee 2 No 3 Probably 4 Unknown ACQUIRED IMMUNOPEFICIENCY SYNDROME Aq 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? HEPATITIS paga 2 s 2 No 1 Yes 2 No certificata 1 Yes Be 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA

certificate be axecuted Box 68760. P.O. Records, of Vitai After this certifical funeral director, I To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Division

Baltimore, Maryland 21215-0020

27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1V2 Naturet 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

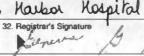
**DHMH 16 Rev 6/95** 

Registrar

Medical

31. Date filed (Month, Day, Year) JUN 2 0 2000

Abhay Moghekar



RESIDENT PHYSICIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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P 11949

JUNE 15

Center, Baltimore, MD - 21225

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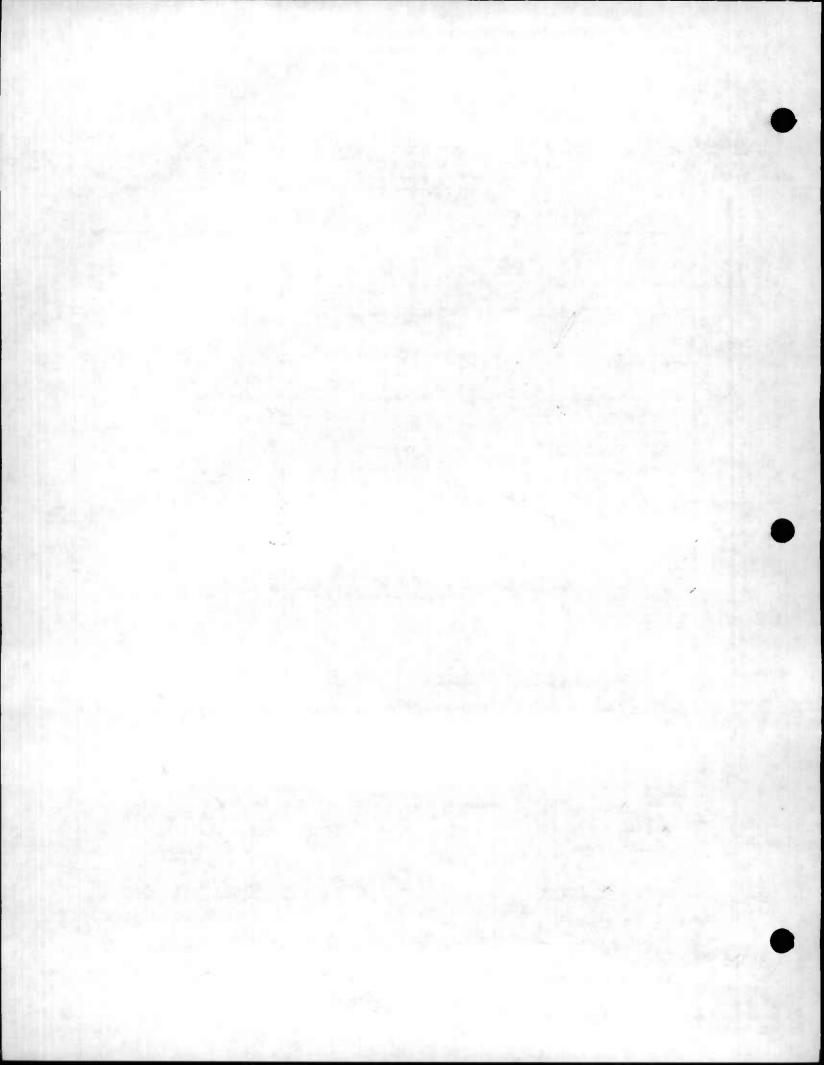
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State of Maryland / Department of Health and Mental Hygiene	00	941	44	-
Certificate of Death				

	1. Decedent's Neme (First, Mid	dle, Last)		301	tificate of I		2. Date of Dea			3. Time of Death
ian ical		ANNA	MAE	JAI	MISON		JUNE :	14 <sup>Day</sup> 2000	OYear	12:10pm
iner	4a Fscility Name (If not instituti	on, give street end number	or)		4	b. City, Town, o	r Location of Death	4c. County	of Deeth	
	1106 Tac	e Drive					sex	]	Balt	imore
4.	5. Social Security Number	6. Sex 7. /	Age (In yrs. last	100	If Under 1 Year Months Days	If Under 24 Hi Hours Mil	n. (Month, Day	Year)	9. Birthp Coun	lece (Stete or Foreign try)
	218-22-4177	ILIM 201F	88	Yrs.			Jan. 31	1912	Sout	h Carolina
	Usual Residence of Decedent  10a. State  10b. Count	N.	10c. City, To	um or Lov	eation				1.	0d. Inside City Limits
7		ltimore	Too. Ony, To	ANT DI CO					Τ.	1 ☐ Yes 2 to No
Š		remore				ssex				
Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V		itry?
runeral	1106 Tace Di					21221			JSA	
Ś	11. Marital Stetus	12. Was Deceder	s?	13. V	las Decedent of H Yes, specify Cuba	lispenic Origin? ( an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Haci	k, White,	an Indien, etc.
	1 Never Married 2 Ma 3 XVidowed 4 Divorce	If Yes, Give		1	☐Yes 2☐No	Specify:		Specify	. Wh:	ite
į				Pa Dagad	antic Haust Occup	etion		16h Kind of Ru	usingse/loc	dueto.
Completed	(Specify only high	est grade completed)		(GIVA)	ent's Usuel Occup aind of work done of ONOT use retired	during most of w	orking	16b. Kind of Bu	ISH NG SWING	Justiy
	Elementary/Secondary (0-12)	College (1-4d	r 5+)		nemaker			AT 75	howa	
5	12th 17. Father's Name (First, Middle	o, Last)		HOL	iciiake1	18. Mother's N	ame (First, Middle,		home	
0	The state of the s	rick W. Mell	ard			2017.17.11	Anna Eva			
2	19a. Informant's Name/Reletion			9h Mellin	Address (Street	and Number or	Rurel Route Numbe		State 7in	Code)
	Steven Foster 20a. Method of Disposition	/ grandson			2411 STON	ieyprook	Road Fal	1ston M		
	1 ⊠ Burial 2 ☐ Cremetion		came	tery, crem	etory or other pled					
	4 Donation 5 Other (		HOTT		1 Cemete	_	6/2000	Baltim	ore l	MD
	21. Signature of Funeral Service	e Licensee	11	22.	Name and Addre		1 Hem	. De-		
	K. TIM	MI Com	My		Connetty	runera	1 Home of	MA 212	21	
	23a. Part1. Enfer the disease, shock, or heert fellure. List	or complications that caus	ed the death. D	not ente	or the mode of dyin	g, such as cardi	ac or respiratory an	rest,	21	Approximate Interval Between
			-							Onset and Death
	Immediate Cause (Final disease or condition	0	NGF	571	VE HE	FART	FAICU	RE		YEARS
	resulting in deeth)	a	Due to (or es	a conseq	uenca of):		, , , , , ,		1	YEARS.
-		(0	0		ONAL	-				YEARS.
Evaluation	Sequentially list conditions.	0.	Due to (or es	-						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that lated accepts.)		74							
POICE	tuat muliaten exemp	С.	Due to (or as	a consequ	ence of):					
9	resulting in death) Lest									
AL P. IV		d							1	
									i	
2	Pert II. Other significant condit	one contributing to death	but not resulting	in the un	deriving cause on	en in Part I	23b. Dld t	obacco use co	ntribute to	the cause of death?
nysici	Pert II. Other significant condit							1.0		
y Physici		LEROTIC						obacco use con Yes 2 No		o the cause of death?
ed by Physici							1 24a. Was	Yes 2 No	3 Pro	bebly 4 Unknown
neted by Physici							1 24a. Was	Yes 2 No	3 Prod	4 Unknown  are sutopsy findings aliable prior to mpletion of cause
mipleted by rugarding							1 24a. Was a perior	an eutopsy med?	3 Prol	ere sutopsy findings ailable prior to mpletion of cause death?
	ATHEROSC	LEROTIL				SEASE	24a. Was a perfor	an eutopsy med?	3 Prol	4 Unknown  are sutopsy findings aliable prior to mpletion of cause
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Registrar DHMH 16 Rev 6/95



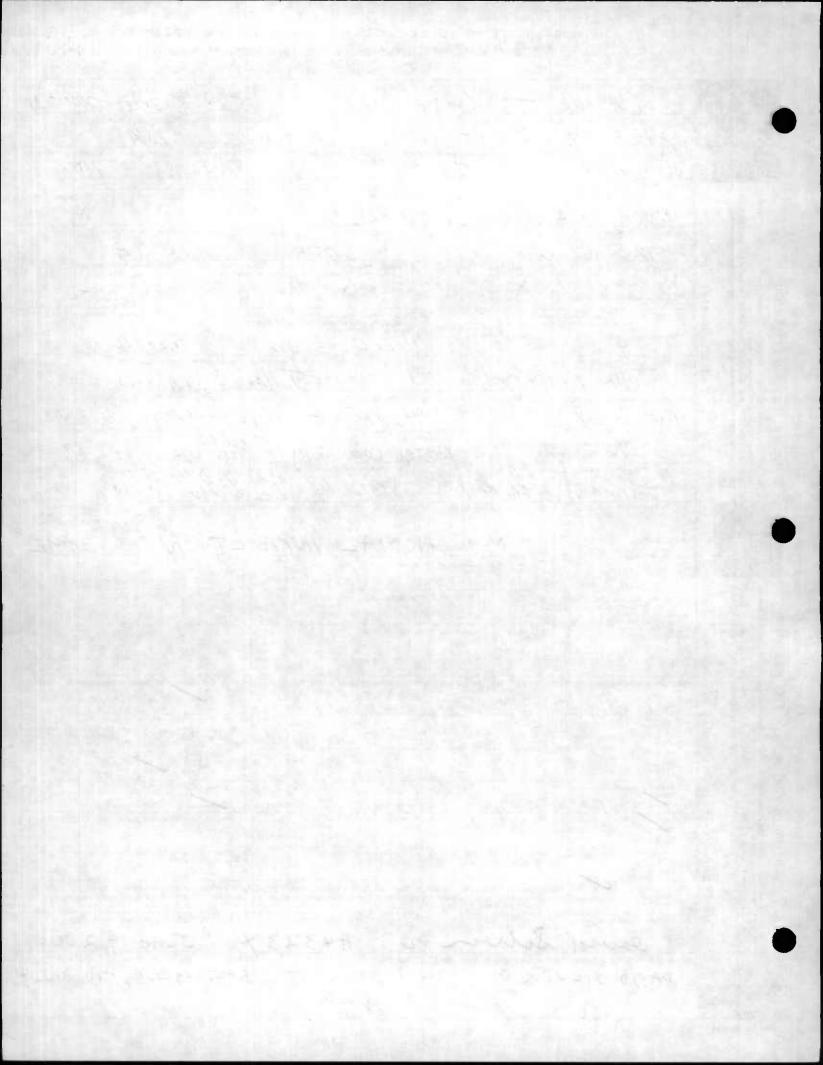
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State of Maryl

and / Department of Health and Mental Hygiene	U		9	4	4	-
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48. Excitly Name (finot institution, give street and number)  49. Cly, Town, or Location of Death  49. Cly, Town or Location  49. Cly, Town or Locati			Cei	rtificate of	Death		Reg. No.	
as Escilla Name (Prior Institution, give street and number)  5. Social Sourch Number  6. Sey  7. Aga (in yas less brinding)  10. Sey  10. Social Sourch Number  10. Sey  10. County  10. Sey  10. Sey  10. Social Sourch Number  10. Sey  10. County  10. Sey	. / '// / / /	die, Last)	10-11	-1).			Day Year	3. Tima of Dec
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Social Scarrier Number    Sept.   19		on, give street and number)			4b. City, Town, o	r Location of Deat	h 4c. County of Deat	th
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20. Carry   10.	X16-18-4284	100 M 201	Yrs.			MARKY	2,190	140.
Too Street and Number    One Street and Number   100 / Zp Code   100 / Cp Code		v	10c. City. Town or Lo	ocation				10d. Inside City I
10. Second   10. Zecond   10.	MAD	1/1						1) Yes 2[
11. Martial Status 12. With Depositor Ever in U.S. 13. Was Decodering of Repent Corpge? (Specify Yes or No. 1) (1) Near Martial 2   Martial 3   Martial 3   Martial 3   Martial 4   Decodering of Repent Corpge? (Specify Yes or No. 1) (1) Near Martial 2   Martial 3   Martial 4   Decodering of Repent Corpge? (Specify Yes or No. 1) (1) Near Martial 3   Martial 4   Decodering of Repent Corpge? (Specify Yes or No. 1) (1) Yes 2   No. 5   Specify: (1) Yes	10e Street and Number	JH 1	DAUIN				10a Citizen of What Co	nunta/2
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O New Married   O Married   Description   O Note   O No	11 Marital Status	12 Was Decedent F	ver in U.S. 13	Was Decedent of	Hispanic Origin?	Specify Yes or No	14. Race · Ame	arican Indian.
15. Decedent's Brain Specified of Specified Sp		Armed Forces?	lo	1		nto Rican, atc.)	Black, While	a, alc.
Commontary/Secondary (1-12)   College (1-for 5+)	. /	d Yes, Give Year or Dates:		1 ☐ Yes 2DTN	Specify:		Specify: // )	HITE
Elementary/Secondary (0-12)   College (1-for 5+)   White Harms (First, Middle, Surface)   White Harms (First, Middle, Surface)   White Harms (First, Middle, Surface)   White Harms (First, Middle, Maidlen Surface)   White Harms (First, Middlen, Maidlen)   White Harms (First, Middle, Maidlen Surface)   Whi	15. Decede	nt's Education	16a. Dece	dent's Usual Occ	upation		16b. Kind of Business	/Industry
17. Father's Name (First, Middle, Last)  18. Mather's Name (First, Middle, Last)  19. Mather's Name (First, Middle, Maskes Summer)  19. Mather's Name (First, Middle, Mi			(Give	DO NOT use retii	e dunng most of w red)	orking		
To the Kropkouski  198. Intigrand's Name/Pelalionship (Pype, Print)  199. Mailing Address (Street and Number or Puril Ributa Number. City or Town, State, 2p Code)  199. Mailing Address (Street and Number or Puril Ributa Number. City or Town, State, 2p Code)  199. Date of Disposition of Disposition of Disposition (Name of Commence)  200. Place of Disposition (Name of Code)  21. Signalement & Commence of Disposition (Name of Code)  22. Name and Address of Fedility, 2p Code of Disposition (Name of Code)  23. Signalement & Commission of The Puril Ributa Number, City or Town, State of Date (Special)  24. Date (Special)  25. Was cased for experience of Puril Ributa Number, City or Town, State of Date (Special)  26. Date (Special)  27. Name and Address of Fedility, 2p Code of Disposition (Name of Code)  28. Date (Special)  29. Date (Special)  29. Date (Special)  29. Date (Special)  29. Date (Special)  29. Date (Special)  29. Date (Special)  29. Date (Special)  29. Date (Special)  29. Place of Death (Check only one)  29. Death (Check only one)  29. Death (Check only one)  29. Death (Check only one)  29. Death (Check only one)  29. Death (Check only	9		WA.	REHOUS	EMAN		WAREHO	USE
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20a. Method of Disposition   20a. Place of Disposition   20a. Location - City or Town, State   City - City	JOHN F	(ROPKOWSK	[]		JOH.	AWNA	KRAKOW	
Burial   2   Committee   Com	19a. Informant's Name/Relation	ship (Type, Print)	19b. Mailin	ing Address (Stre	et and Number or f	Rural Routa Numb	per, City or Town, State, .	Zip Code)
Due to (or as a consequence of):   Sequentially list conditions contributing to dealth but not resulting in the underlying cause given in Part I.	KIM LAHEV	′	104	MONIKE	PSE U	1; WIAN	MSBURG, L	14.23/88
21. Signature of Experial Service Learnese  22. Name and Address of Febrilly, 3.9 (Location Completed Cause Characteristics)  23. Part Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respitatory arrisal.  Approximate characteristics are considered to the cause of the consideration of the cause		• EB 11 6	20b. Place of Dispo cemetery, cree	osition (Name of matory or other p	(ace)	Date 19	20c. Location - City or	Town, State
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shock, or heaf failure. List only one cause on each line.  Initiate Between Condition and address of person who completed cause (Final disease or coordition resulting in death)  Bue to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury hat initiated wents resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury hat initiated wents resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury hat initiated wents resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury hat initiated wents resulting in the underlying cause given in Part I.  23b. Did tobecco use contribute to the cause of 16 Vere 2 In No 3   Probebly 4   Ut 24   Ut 24   Wars an autopsy performed?  24c. Was an autopsy performed?  25c. Was case referred to medical example?  1   Vere 2   No   1   V	21. Signature of Europeal Service	Libensee / /) //	25	2. Nama and Add	ress of Facility	79 1/11	011 57.	1111
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Ctota of Mandand	Department of Licelth	and Mental Hygiene
State of Maryland	Department of Health	and Mental Hydiene U

AMEND ITEM: 7,8 PER MEO G784 6-20-00 WR. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 2000 **Physician** 11:30 A.M. June 19, KO /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lutherville Baltimore 1520 Melton Rd. If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. | 7. Age (In yrs. last birthday) 8. Date of Birth 934
July 07, 1935 9. Birthplace (State or Foreign Seoul, Korea 5. Social Security Number 6. Sex **Funeral** 1 M 2XXF 218-13-8014 -64 Yrs. Director Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d Inside City Limits mant be notified at 1 ☐ Yes 2 No Baltimore Co. Lutherville Funeral Director Mary land 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23s or 21093 Korea 1520 Melton Road 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status Peges 1 and 2 should be filed within 72 hours efter 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2XXMarried Saltimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: Korean Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Store Convenience Store Owner n/a 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) Department of Health end Mental Important: If Item 27 is marked or eny Injury or other treumatic eve Jong Eun Kim Ki Myong Choi 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, Cify or Town, Stete, Zip Code) Towson, Maryland 21286 Mr. Jay S. Ko (Son) 501 Stevenson Lane 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c Location - City or Town State 1 € Burial 2 Cremation 3 Removel from State 6/24/2000 Nam-Han-Kang Gong-Won-Myo-Ji Yeo-Ju, Korea 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Jeffrey L. Gair 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204-2515 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but only only leuse on each line. Approximete Intervat Between Onset and Death **Physician** myeloid leukemia /Medical Immediate Cause (Final months disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as e consequence of): Bnd Box 68760. physician **Physician/Medical** Due to (or as a consequence of): 98 USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? be detached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. edicai Certification: To Be Completed by 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy performed? page 2 : certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funeral Director: After this certifica 25. Was case referred to medical 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5 Residence 6 □Other (Specify) 1□ Yes 2☑ No the funerel 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as atated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 36131 0 30. Nama and address of person who completed cause of death (Item 23e) (Type, Print) M. D rave cchae 32. Registrer's Signeture State Registrar

JUN 2 0 2000 James

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $\mathbb{U}\,\mathbb{U}$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 434 Grongard 2000 atricio /Medical 4a Fscility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Cir N/A HOP 5. Social Security Number INS 8. Date of By In (Month, Pay, Year) 6. Sex Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days IDM XX 60 Yes. 215-42-9214 04-14-1940 Director MARYLAND Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show il Hygiene. other than "natural", or flerna 23a or 28a-f show vent, the Medical Examinet must be notified at MD. BALTIMORE LUTHERVILLE 1 ☐ Yes 2 Funeral Director 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 21093 1400 WEST SEMINARY AVENUE U.S.A. 14. Race - American Indian, Biack, White, etc. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after ☐ Yes XX No Yes, Giva 1 Never Married MMarried Maryland 21215-0020 1 ☐ Yes XX No Specify. þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME PLUS permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg
Important: If Item 27 is marked other
any injury or other traumer: 18. Mother's Name (First, Middla, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ALBERT LION GLORTA **AMBURGH** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1400 W.SEMINARY AVE., LUTHERVILLE, MD. 21093 A. B. KRONGARD (HUSBAND) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal Irom State GREEN MOUNT CREMATORY 6-17 BALTIMORE, MD., 21202 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY W. JENKINS AND SONS COMPANY 21. Signature of Funeral Servica Licensee utt 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final 2 weeks disease or condition resulting in death) cl Examine Due to (or as a consequence of): Examine The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated evants resulting in death) Last bunal-tran Bud Due to (or as a consequence of): Box 68760, attending physician for use as the bune Physician/Medical Due to (or as a consequenca of): 88 P.O. ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 70 3 Probably 4 Unknown of Vital Records. þ 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificate has 2□ No 1 ☐ Yes 2 No Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Opatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred if or Attending P Division 1 Natural 2 Accident 5 Pending investigation after death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 certifying Physician: To tha best of my knowledga, daath occurred at the time, date and place, and due to tha cause(s) and mannar as stated.
2 Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha time, data and place, and due to tha cause(s) and mannar stated. 29a. Certifier Medical 29d. Dete signed (Month, Day, Year) 29b. Signature a 29c. License number RES-000

Registrar

State

DHMH 16 Rav 6/95

Room

books

110

JOHNS HOPKINS

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print)

DWER

32. Registrar's Signature

Geneva

SEO

JUN 2 0 2000

THILIP

31. Date liled (Month, Day, Year)

Little Kennyaca Janes 18 8860

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 19448

AMEND	ITE	MS: #23 PART I, 2	7, 28A-F P	ER ME	366	tificat	e of	Death			Reg. No	).				
Physici	an	Decedent's Name (First, Middle, Last)						2. Data of De Month	Day Y		Year		ne of Death			
/Medic		Luaries waller Lanenart								June 1	5, 2	900		7:	16 PM	
Examin		4a Facility Name (If not Institution, give	street and number)					4b. City, To	wn, or L	ocation of Deat	h 4c	. County	of Death		- 1	
		2848 Pennsylvania Avenue Baltimore Baltimor							Lmore							
Funeral Director		5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) H Under 1 Year 217-58-1628 1 M 2 F 44 Yrs. Months Days				If Under Hours	24 Hrs. Min.	8. Data of Bir (Month, Di Sep. 3	IV. Year	55	9. Birthpli Count Mary	'ry)	ate or Foreig d			
inyland thow		Usual Residence of Decedent  10a. Stata 10b. County		10c. City, To		cation							10		de City Limit	
To be Completed by Funeral Director  To Be Completed by Funeral Director	5	Maryland Baltimor	re	Balti	more					16.11	1 □ Yes 2 1 1					
									10g. Citizen of What Country? USA							
	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	Ever in U,S. No	U.S. 13. Was Decedent of Hispanic Origin? (Specifi If Yes, specify Cuban, Mexicen, Puerto Ric 1 ☐ Yas 2 ☒ No Specify:				Rican, etc.) Black, Wh			k, White, a	narican Indian, lite, atc. hite				
72 ho	Completed	15. Decedent's Ed	15. Decedent's Education				ai Occup	pation	t of work	16b. Kind of Bus			siness/Ind	ustry		
within 7 ene. then "r	Pe e	(Specify only highest gra-	Coilege (1-4or 5	+)	life. E	DO NOT u	se retire	during mosi d)	t or work							
be filed within tal Hygiens. d other than event, the Manager than the mana	No.	12	0	C	orre	ction	nal	Office	er	r Deter				ntion Center		
al Hygid other vent, t	Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Nam	e (First, Middle	, Maider	Sumam	(e)			
	70	Charles Lanehart						Lev:	Levina Davidson							
d 2 should be th and Menta 7 is marked of traumatic ev		19a. Informant's Name/Ralationship (7	ype, Print)	19	b. Mailin	g Addras:	(Straa	and Number	er or Ru	r or Rural Route Number, City or Town, State, Zip Code)						
127 T		Richard Bussey / 1	Brother	9	613	North	nwin	d Road	d, B	altimor	e, N	Maryl	Land :	2123	34	
		20a. Method of Disposition	37.00m	20b. Place	20b. Place of Disposition (Name			cel		Date	T		City or Tox	City or Town, Stata		
Pages nent of mrt: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Cremation 3 Li Hemoval from State			cometery, crematory or other place) tro Crematory, Inc			16	/20/00	O Baltimore, Maryla			land		
in party		21. Signal Funeral Service Licen		1.0010				ess of Facilit		, _ , , ,						
Depa impo eny ii		· Unn y.	3inl	,						e, Inc. , Balti	more	e, Ma	aryla	nd 2	21229	
		23a. Part 1. Enter the disease, or companies shock, or heart failura. List only	s that ceused	the death. Do	not ente	er the mod	le of dyi	ng, such as	cerdiac	or respiratory a	rrest,			Approx	imate Batwaan	
Physician														Onset	and Death	
/Medical		Immediate Cause (Final disease or condition ALCOHOL AND OXYCODONE INTOXICATION							'TON							
Examiner		rasulting in death)  a  Due to (or as a consequence ot):														
70 .2	ner		ALIE CONTRACTOR													
cute	Examiner	Sequentially list conditions,	b.  Due to (or as a consequence of):													
an al		Sequentially list conditions, if any, leading to immediate ceuss. Entar Underlying Cause (Disease or injury								1						
te be ysici	edical	I that whitated events														
eath certificate be executed attending physician and for use as the bunal-transit	2															
ath co	lan		u.										i			
he atten	Sic	Part II. Other eignificant conditions co	eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the ceuse of					use of deat	
uires that the death co signed by the attend Id be detached for us	y Physician/						1 Yes 2 No 3 Probably 4				4 Unkno					
Physician: The law requires the tribic certificate has been signed rail director, page 2 should be director. To Be Completed by	bed							performed? avai			ilabla p					
> 13 er	ple												completion of cause of daath?			
The lay	E O									1 O Yes 2 □ No			1	Tyes	2 No	
	BeC	25. Was case raferred to medical						26. Place	of Deat	h (Check only	one)		-			
Physician: this certific ral director,	To B	examiner? 1 DX es 2 DNo	Hospital; 1 ☐ Inpatie	nt 2∏FB/0	Outpatien	1 3 D	DA Ot	hor				6 XIOth	ar (Specify	1) 80	rene	
La or Attending Physical or attended to the following the funeral did in by the funeral did Certification: To		27. Manner of Death	28a. Date of Injury 28b. Time of P 28c. Injury at					Home 5 ☐ Residence 6 🖫Othar (Specify) SCENE  28d. Describe how injury occurred								
	힅	1 Naturat 5 Pending 2 Accident investigation	FOUND: M Work? 1 Yes 2 XNo 28e, Place of Injury - At homa, farm, streat, factory, office			No	UNKNOWN									
or Attendation of Director:	fice	3 ☐ Suicide 6 🖾 Could not be					281. Location (Street and Number or Rurel Route Number of City or Joyan, State) 2848				Number					
after Dire	eri	4 Homicide determined determined determined building, etc. (Specify)  RESIDENCE							AVE BALTIMORE, MD.							
To the Hospital or Attending Phymitin 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral	edical C	(Check only 2 Medical Exam	ysician: To the best of iner: On the besis of	of my knowledge axamination a	e, death	occurred restigation	at the ti	me, date an opinion, daa	d place, th occur	and due to tha	causa(s	s) and ma id place,	annar as st	atad.	use(s)	
within 2 To the comple	Med	29b. Signature and title of certifier	and manner sta	red.		20.	c Licen	se number			29d D	ata sione	d (Month )	Day Ve	wer)	
5 × 6 0		250. Signature and title of certifier	11. 1		1	29								(Month, Day, Year)		
		Theolog M.	Kirga	2			0.0	C.M.E.			June 16, 2000					
		30. Name and address of person who d	completed cause of de	eath (Item 23a	(Type, I	Print)					160					
		THEODORE MIK	- cuf		111	Penr	St	reet,	Bal	timore,	Mar	ylan	d 212	201	1,117	
Sta	te	31. Data filed (Month, Day, Year)	32. Registra	ar's Signatura	6	-										

JUN 2 0 2000 DHMH 16 Rev 6/95

JUN 2 0 2000 James A. Janes

## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

If Under 1 Year

 1	0	1	2	-
	U	1	1	(
-	9	unda.	-5	46

EDITH LOLIES

> **Physician Medical**

1. Decedent's Name (First, Middle, Last) Edith Mary Lolies

1□M 20 F

2. Date of Death Day Month

3. Time of Death

**Examiner** 

4a Facility Name (If not institution, give street and number) 500 E. PONTIAC AVE

4b. City, Town, or Location of Death BALTIMORE

14,2000 6:07P.M. 4c. County of Death

N/A

**Funeral** 

578-58-6221 Usual Residence of Decedent 10b. County

5. Social Security Number

Months Hours 55 Yrs

7. Age (In yrs. last birthday)

10c. City, Town or Location

If Under 24 Hrs.

JUNE

9. Birthplace (State or Foreign Country) DISTRICT COLUMBIA

10d. Inside City Limits

Approximete Interval Between Onset and Death

completion of cause of death?

1 Yes 2 No

1 ☐ yes 2 ☐ No

of

Director

with the Maryland 10a State

Itam 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Completed by Be

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumers.

Physician /Medical Examiner

The law requires that the death certificate be executed ed by the attending physician and detached for use as the bural-trans Box 68760, of Vital Records, P.O. signed by t Division

After this certificate has septal or Attanding Physician: Thours after death.

neral Director: After this certificat
by filled in by the funeral director, pu To the Hospital within 24 hours a To the Funeral Completely filled

27. Manner of Death

2 Accident

4 ☐ Homicide

29b. Signature end title of sertifier

3 Suicide

29a. Certifier (Check only one)

31. Date

5 Pending Investigation

6 ☐ Could not be

3"2000

Funeral Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 500 Pontiac Road 21225 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 □ Yes X□ No Specify Specify: White 3 Widowed Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Translator NSA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Vincent Tracy Stephanie Ann Sliz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6621 Deep Run Pkwy., Elkridge, MD 21075 Deanna Lolies/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stete Metro Crematory, Inc. 6/19/00 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatural Funerel Service Krainsee 22. Name and Address of Facility Cremation Society of Maryland, Inc. Edward A O Gregorchik 299 Frederick Rd. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respirelory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Examiner P a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Due to (or as a consequence of) Quies significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Was an autopsy performed? ermi 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify SCENE 1 TYPes 2 □ No 1 ☐ Inpetient 2 ☐ ER/Outpatient 3□ DOA

State Registrar

**DHMH 16 Rev 6/95** 

Medical

**ORIGINAL** 

28a. Date of Injury (Month, Day Year)

s of person who completed cause of death (Item 23s) (Type, Print) es

32. Pégistrar's Signature

28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

rang

29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number O.C.M.E.

28d. Describe how injury occurred

111 Penn Street, Baltimore, Maryland 21201

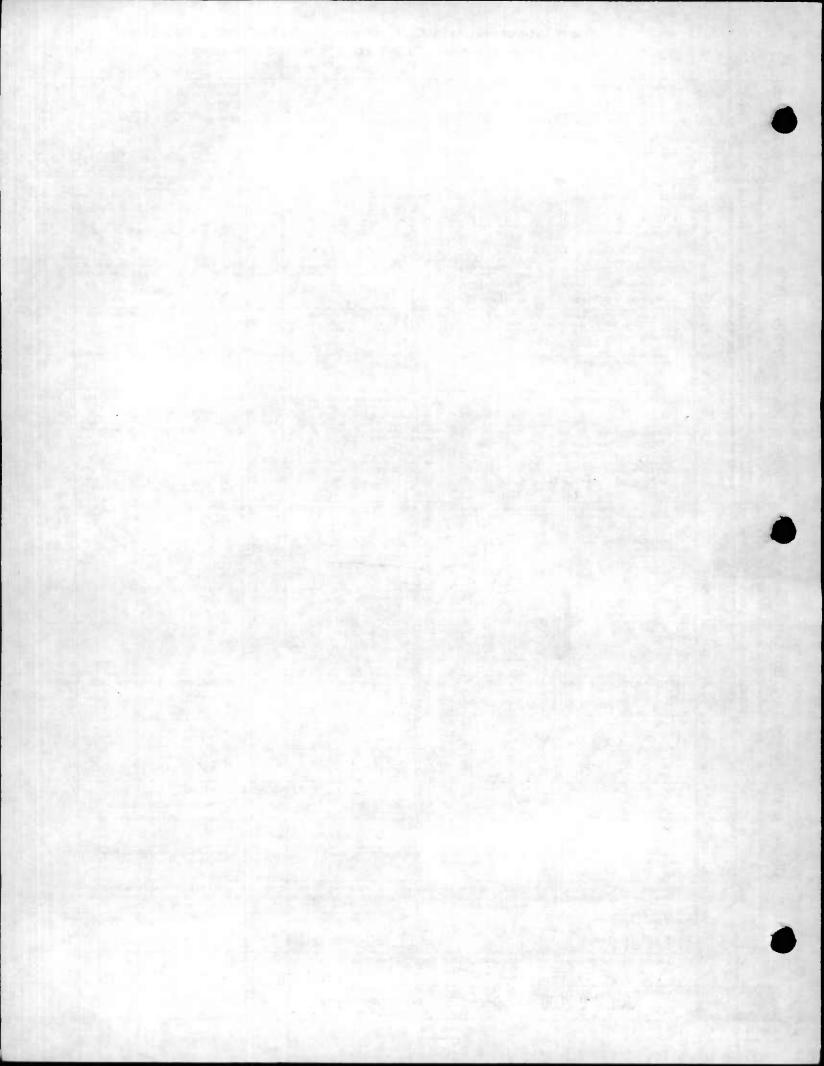
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

28c. Injury at Work?

1 Yes 2 No

JUNE 15,2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #10e PER FH G784 6/20/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month **Physician** LEVIN SYLVAN 1206 AM June /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Inder 24 Hrs. 8. Date of Birth pay, year, NOV 24 1914 N/A HOSPITAI If Under 1 Year 5. Social Security Number 6 Sex Birthplaca (State or Foreign Country)
 MD • 7. Age (In yrs. last birthday) **Funeral** Days 10M 20F Yrs. 216-07-1301 Director **Usual Residence of Decedent** 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits iges 1 and 2 should be filed within 72 hours after death with the Maryles it of Health and Mentale hygiens.

In of Health and Mentale hygiens that the first of them 23a or 28af show or other treumstic event, the thindisal Example mean be notified. 1 Yas 2 No BALTIMORE BALTIMORE MD 10e. Street and Number 6527 GARDENWICK ROAD 10f. Zip Code 10g. Citizen of What Country? 21209 USA Funeral Known as Sylvan 1 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes TNO Specify: SpecifyWHTTF. à 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CERTIFIED PUBLIC ACCOUNTANT ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 DANIEL LEVIN TDA FRIEDMAN 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 si Depertment of Health and Important: If Nem 27 Is m. any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRENE LEVIN/ WIFE 6527 GARDENWICK ROAD BALTIMORE, MD. 21209 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH JACOB CONGREGATION 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/18/00 FINKSBURG, MD. 21. Signature of Funeral e licens 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part1. Enter the shock, or heart la complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, List only one cause on each line. **Physician** 36 hrs /Medical Immediate Cause (Finat disease or condition resulting in death) Examiner Due to (or es a consequence of): Physician/Medical Examiner -ail physician and s the burel-trensit The law requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Failure Due to (or es a consequence of): P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown ronns Records. Completed 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? cartificata or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitat: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes & No 2 ER/Outpatient 3 DOA 유 After thi funeral 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 6 Natural 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

Division of Vital

To the Hospital or Attendiwithin 24 hours after death.
To the Funeral Director: A complately filled in by the fu Registrar

State

Gasto 31. Date filed (Month, Day, Year)

4 Homicide

29b. Signature and title of continue

29a. Certifier (Check only one)

JUN 2 0 2000

h 23a) (Type, Print)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Belvedere

Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

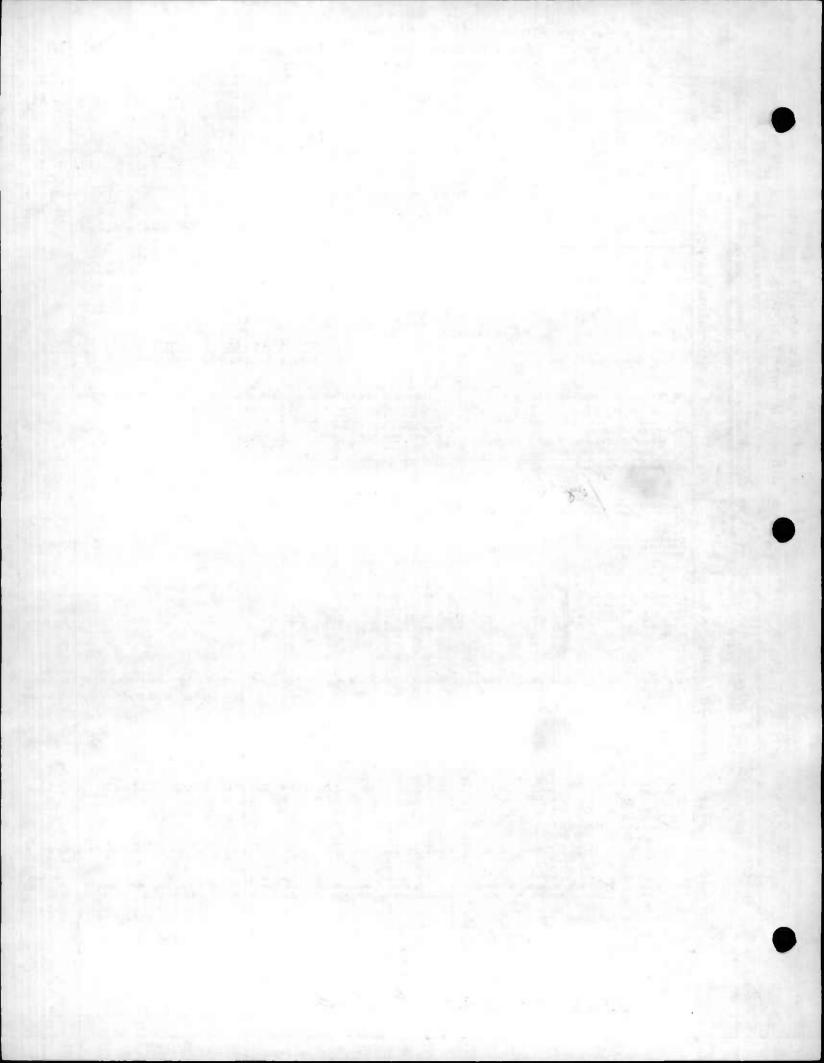
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29c. License number

, Smai Hospital

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day MARY MEGGINSON **Physician** :50 A.M. 2000 /Medical 4c. County of Death 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Bon Secours Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2XX Days Yrs. Director 229-44-7223 07-20-1922 **Virginia** Usual Residence of Decedent the Marylend 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County ahow r 28a-f ahow Yes 2□No Funeral Director Md. N/A Baltimore 10e. Street and Number 10g, Citizen of What Country? 10f. Zin Code 8 132 N. Culver Street 21229 USA 238 Remai 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes XXNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Merried 2 Married 8 1 ☐ Yes XXNo Specify. Black Specify: Completed by 3 XWidowed 4 □ Divorced Year or Detes: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health end Mental Hyglene. Important: If Item 27 Is marked other than any Injury or other traumatic avent, the Medica. Elementary/Secondary (0-12) College (1-4or 5+) 8 th Homemaker Domestic Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ed Robinson Hattie E. Jackson 19a. tnforment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Ann Megginson (Daughter) 132 N. Culver Street. Balto., Md. 21229 20a. Method of Disposition

1 Burial 2 Cremation 3 Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 6/19/00 Arbutus, Maryland 22. Name and Address of Fecility of Funeral Se Caple Funeral Service 5502 Winner Ave. Balto., Md. 21215 , or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, list only one cause on each line. Part1. Enter the disease shock, or heart feilure Approximate Interval Between Onset and Death **Physician** tmmediate Cause (Final disease or condition resulting in death) Incumonia Examiner Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of): hemic The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): USB BS P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Wunknown Heart Failure þ of Vital Records, 24a. Was en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Be Completed Node Disease 1 ☐ Yes 20 No 1 Yes After this certificate is after death.

Is after death.

In Director: After this certificated in by the funeral director, pe 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA edical Certification: To 28b. Time of 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of tnjury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29e. Certifier \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es steted.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of certifier 29c. License number 022342

**DHMH 16 Rev 6/95** 

State

Registrar

2000

W. BALTIMONE St., BALTIMONE, M.D. 2123

30. Name and address of person who completed ceuse of deeth (Item 23s) (Type, Print)

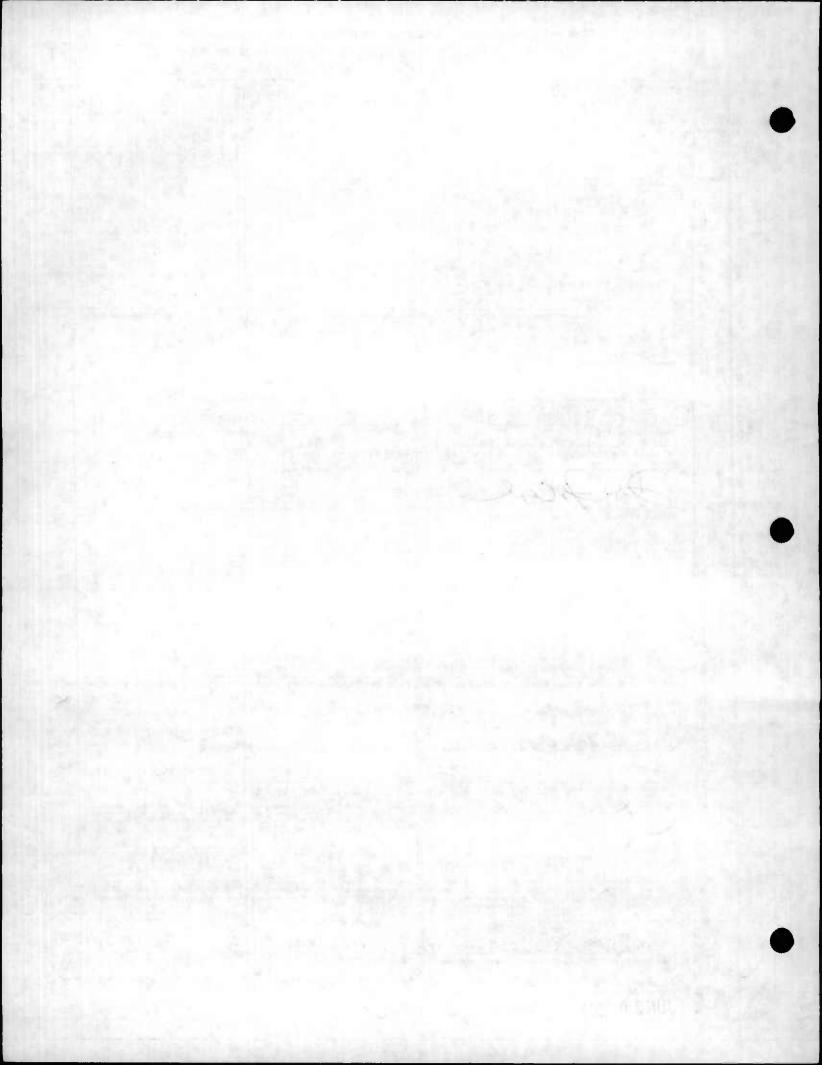
RUBINSTKIN, M.D.

32. Registrar's Signature

N.

TICHARL 31. Date filed (Month, Day, Year)

JUN 2 0 2000

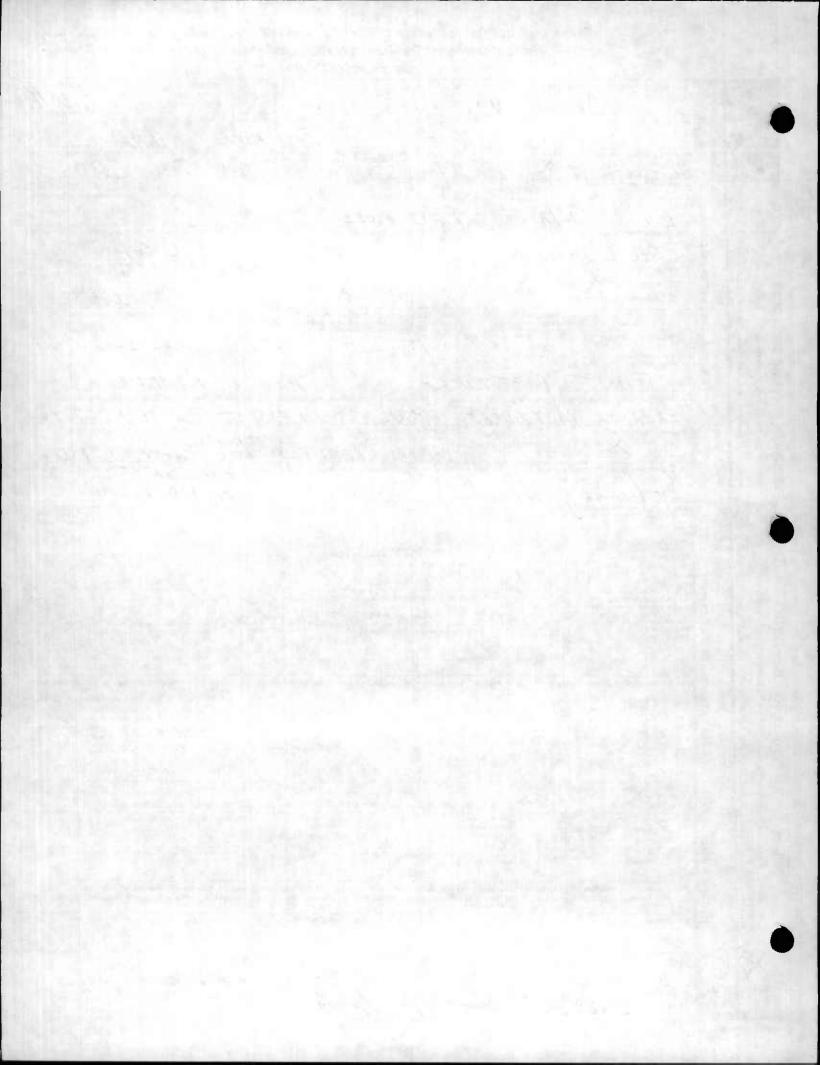


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State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No.	
Physician	1. Decedent's Name (First, Middle, Last)	Dete of Deeth     Month Day Ye	ar 3. Tima of Death D
/Medical	4a Facility Nama (If not institution, give street and number)  4b. City, Town, or Lo	6 7 200	
Examiner	+ 1111 1/2 1/2		peetn
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs, fest birthday) If Under 1 Year If Under 24 Hrs.		Birthplace (State or Foreign
Director	2/2-34-2897 12M 20 F 64 Yrs. Months Deys Hours Min.	JUNE 1, 1936	Country D.
D.	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location		10d. tnsida City Limits
Meryland He ahow fled at	110		12 Yes 2 □ No
with the Me Le or 28a-f be notifie	10e. Street and Number 10f. Zip Code	10g. Citizen ot What	t Country?
23a or	3216 0 DONNELL ST. 21224	10.5.	4.
dea dea	11. Mental Status  12. Wes Decedent Ever In U.S. Armed Forces?  13. Wes Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	American Indien, Vhite, etc.
hours after hours, or he	1 Nevar Married 2 Merried 1 Yes 2 No 1 Yes 2 No Specify:	Specify:	1.111:5
	3 Wildowed 4 Divorced Year or Detes:  15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Busine	DHIE ass/Industry
1 21215-0 led within 72 ho tygiene. or than 'neturi it, the Medical Completed	(Specify only highest greda completed) (Give kind of work done during most of work)  Elamentary/Secondery (0-12)  Collega (1-4or 5+)	ing	
212. d withing glene.	MACHINE OPERATER	e MARYL	AND CUP
be filed to the dother avent, to Be Co		(First, Middle, Maiden Sumeme)	
should by the Menta Menta and Menta	JOHN T. METZDORF MARY	E. KANDAL	
Maryiand d 2 should be file th end Mental Hy 7 is marked oth traumatic avent	19e. Informant's Name/Raletionship (Type, Print)  19b. Meiling Address (Street and Number or Mun  21/1 8 2 1/1	77	11 7 7 7
is 1 and 2 should be filed and 4 should be filed to 4 should be filed by them 27 is marked other traumatic avent,  To Be C	20a. Method of Disposition  20b. Place of Disposition (Name of	Data 20c. Location - City	or Town, State
0 80= 5		2000 BALTO.	CO. MD.
프 등 등 등 등	21. Signature of Eunaral Sarvice Licensee 22. Nama end Address of Fegulty 2	ma Llurger 5	T
Ba Depa Impo	+ house h. Sky la V. SKARDAFEH. B.	LITO MD. ZIZ	224
	23e. Pert1. Enter the disease, of complications that caused the death. Do not anter the mode of dying, such as cardiac shock, or heart lailura. List only one cause on each line.		Approximete tritarval Batween
Physician			Onset and Death
/Medical   Examiner	Immediate Causa (Finel disease or condition as a		
	Due to (or es a consaquance of):		
executed on and intransit	b.		
	Sequantially list conditions, if any, leading to immediate cause. Enter Undertying Ceuse (Diseasa or Injury	4576	
oentificate be exceptional ding physicien ise as the buria	Ceuse (Diseasa or Injury that initiated events resulting in deeth) Lest  Dua to (or as a consequanca ot):	7	
2 2 2			
0 - 63 -			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Dtd tobacco uas contrit	
that that hed by y	Coroney Arthy Dijork	12Nos 2□ No 3[	☐ Probably 4 ☐ Unknown
cequires that the requires that the seen signed by the hould be detach thought by the steed by Physics	Hypercus ( Estel man	24e. Wes en eutopsy 2 performed?	4b. Wara eutopsy tindings available prior to
law respect to the sea peed to	Pyperhalto I Estad Enor	periormed	complation of causa of death?
The law requirements has been single 2 should Completed		1 □ Yes 2 No	1 ☐ Yes 2 ☐ No
/Ita	examiner?	h (Check only ona)	
Of Vital Re Physician: The I this certificate he ral director, page : To Be Com	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5 Rasidance 8 Other (	Specify)
Division of Vital Records, or Attanding Physician: The law requires the dear death. The taw requires the director. After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed by	1 Neturel 5 Pending (Month, Day Year) Injury Work?	28d. Describe how Injury occurred	
Attending reference Attending by the fune	3 Suicide 6 Could not be 28e. Place of Injury - At home, term, street, factory, office	28f. Location (Street end Number of	or Rural Route Number,
Div din the din the	4 ☐ Homicida building, afc. (Specify)	City or Town, State)	
To the Hospital or Attanding Pleating 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier  (Check only  29a Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.		
the H the Fi the Fi	one) end menner stated.		
To the with	29b. Signatura end title of certifier	29d. Dete signed (A	Ponin, Day, Year)
AN	0116	610	
0	30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)  Simon Scalia 2801 Hudson St Bal	H. Md 21224	
State	31. Dete filed (Month, Day, Year)  32. Registrer's Signature  32. Registrer's Signature  4. Spark	H, MC 21 224	
Registrar	JUN 2 0 2000 Serve & sparks		

DHMH 16 Rsv 6/95

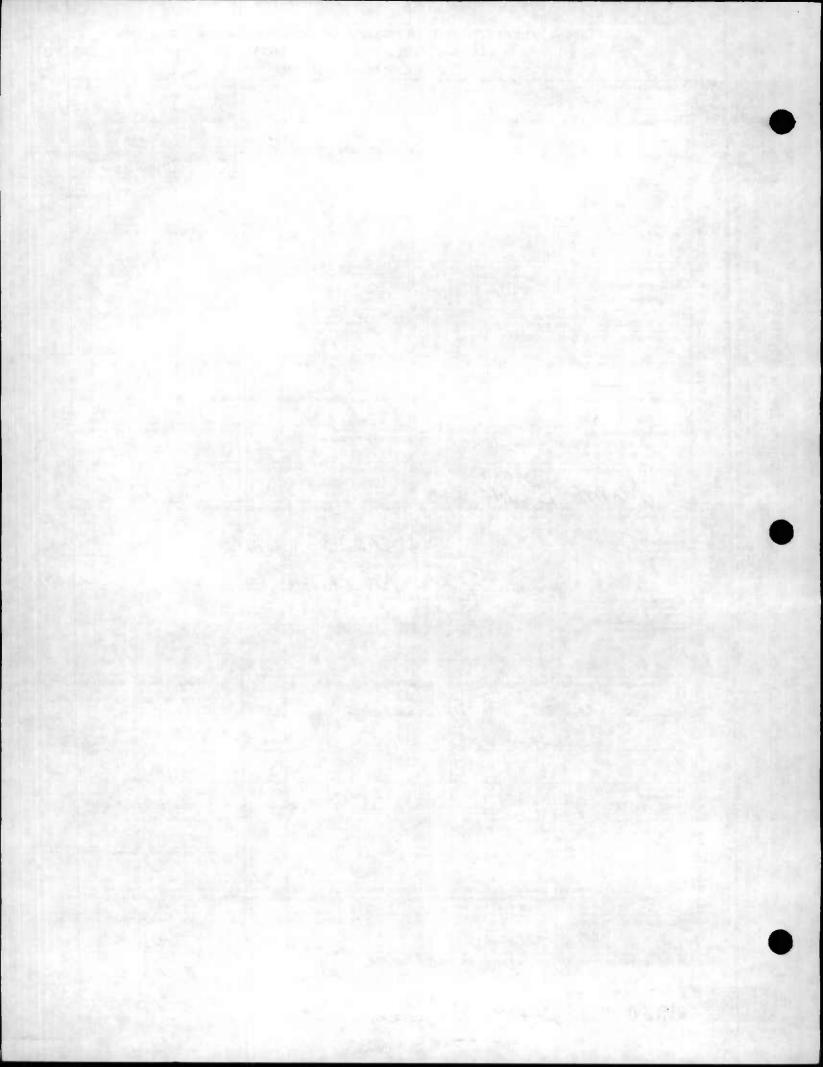


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	3				Certificate	e of			g. No.			
	Physician	Decedent'a Name (First, Middle, I	ast)					2. Date of Death Month		rear	3. Tima ot Death	
	/Medical	Bessie M	arie Mer	son				June 1	3, 2000		1:50 PM	
	Examiner	4a Facility Name (If not institution, g	ive street and riumber	)			4b. City, Town, or L	ocation of Death	4c. County of	Death		
100		Manor Care Rola	nd Park				Baltimo	re	N/	Δ		
	Funeral		Sex 7. A	ge (in yrs. last bi	irthdey) If Under		If Under 24 Hrs.	8. Date of Birth		9 Birthoi	ace (Stete or Foreign	
	Director	217-09-2601 Usual Residence of Decedent	1□M XXF 8	39	Yrs. Months	Days	Hours Min.	Aug. 30,	1910 M	aryl		
6	8 1	10a. State 10b. County		10c. City, Tov	vn or Location					10	Od. Inside City Limits	
9		Maryland N/A		Ra	ltimore						Yes 2 No	
4	t or 28a-f s be notified Director	10e. Street and Number	<u> </u>	100.	10f. Zip	Coda		10	g. Citizan of Wh	nat Count	try?	
4	23e or 28e-f show		CONTRACTOR OF									
1	r heme 23s	4525 Schenley	Road 12. Was Deceden	t Ever in II C		2121		ont Vec or No.	USA 14. Race		an Indian	
	Rems her m	11. Maritai Status	Armed Forces	?	If Yes, spec	ify Cub	Hispanic Origin? (Sp ean, Mexican, Puerto	Rican, etc.)		White,		
21215-0020	b F.	1 □ Never Married 2 □ Married 3 ₩ Widowed 4 □ Divorced	1 ☐ Yes 2 5 If Yes, Give Year or Dates		1□ Yas	R No	Specify:		Specify:	white		
5-0		15. Decedent's (Specify only highest of		188	Decedent's Usua	t Occur	pation during most of worked)	ing 1	6b. Kind of Busi	f Business/Industry		
7	than the	Elementary/Secondary (0-12)	Cotlege (1-4or	5+)	life. DO NOT us	e retire	od)					
	Hygiene. ther than	6			Assembly	Lir			Mt. Ve		Mill	
ם	ETSE A	17. Fathar's Name (First, Middle, La						e (First, Middle, M	13.0			
0	Mental Serked o atic eve		Ba	rnes			Cathe	rine M	c Cule	У		
Maryland	DEE	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Address	(Strea	t and Number or Ru	el Route Number,	City or Town, S	tete, Zip	Code)	
	Health a sm 27 is sm 27 is sm 27 is sm 27 is	Donald Merson	Son		4525 Sc	cher	ley Road,	Baltimo	re. Mar	vlan	d 21210	
ē,	E e e	20a. Method of Disposition		20b. Ptace	of Disposition (Nen	ne of			Oc. Location - C	_		
Baltimore,	of H	1 Burial 2 Cremation 3						6/16/00	Sagarett	1110	, Maryland	
<u>`</u> ≡ °;	permit. Pages Department of Important: if its sny injury or o	4 Donation 5 Other (Special Signature of Famoral Service Lice	*	TARREST			ess of Facility	0/10/00	bcaggsv	1116	, riaryrand	
Ba			()	unnl	Distance	TTe	man Caiba	Funeral	Home,	Inc.	21211	
		23a. Part Entwithe disease, or co shock, or heart failure. List on	mplications that cause	ed the death. Do	not enter the mod	e of dyi	ing, such as cardiac	or respiratory arre	st,	and	Approximate	
	hysician	shock, or heart faiture. List on	ly one cause on aach	tine.						1	tntarval Batween Onsat and Death	
	/Medical	Immediate Cause (Final			ove Dia	200	Ru en				1014	
	xaminer	disease or condition rasulting in death)	a		KES I'ICI	עודו	RY FA	LURE			2 HOURS	
				Due to (or as a	consequence of):		1				^	
-	s ti		b		ASSII	Rp.	TION PI	KUHONI	A		2 HOURS	
	physician and sthe burial-transit	Sequentially tist conditions,		Due to (or as a	consequence of):							
68760,	Sian Sian	Sequentially tist conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or injury										
87	physicia as the bur edical	that initiated events resulting in death) Last		Due to (or as a	consequence of):							
9												
. Box 68760,	d by the attending etached for use a Physician/M		d			1				i		
- T	sic ed fe	Part II. Other significant conditions	contributing to death	but not rasulting	in the underlying ca	ausa gi	ven in Part I.	23b. Dld to	bacco uas cont	ributa to	the cause of death?	
P.0	igned by the a libe detached by Physic	00000	- 6-0 AA	OGANA C.	1 - 1 05			1 🗆 Ye	s 2 No	3 Prot	bebty 4 Unknown	
	be de de de de de de de de de de de de de	GENERALI	(55 ) VA	1 UHOX	LETUS 1							
5	es been signed by the 2 should be detached by the 2 should be detached by Physical By Phys	JENERAU DEME	0					24a. Was an		24b. We	ere autopsy findings allable prior to	
8	shoul	1) Ey &	NTH.	- 1, 2, 4,				perom	leur .	COL	mpietion of cause daath?	
Be :	9 - 6 - 5								4574			
<u>a</u>	S ag							1 ☐ Ye	s 200No	11	Yes 2□ No	
of Vital Records,	this certificate ral director, pag	25. Was casa raferred to medicel examiner?	Hospital:				hor: A	th (Check only on				
to	T T	1 Yes 2 No	1 L Inpai			<b>'</b> ^		ome 5 Rasida			y)	
-	B 9 9 E	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	ey Year) 28b.	Time of 2 Injury	Bc. inju		28d. Describe ho	w injury occurre	d		
0 3	or death.  ector: After by the fune	2 Accidant invastigat			М		Yes 2 No					
Division	and of a state of a st	3 Suicide 6 Could not determine		28f. Location (St. City or Town	reet end Numbe , Stete)	r or Rura	l Routa Number,					
	Ser Ser Ser Ser Ser Ser Ser Ser Ser Ser			(,	arm, street, factory							
grand	uniting 24 hours after death, within 24 hours after death. To the Fureral birector, Aft completely filled in by the fur Medical Certificatio		Physician: To the bes									
-	in 2.										APRIL BEST	
	To the	29b. Signature and title of certifier			290	. Licen	se number	25	d. Date signed	(Month,	Dey, Year)	
		) Ild	1 M.g.			D	22609		JUNE 1	5. 2	000	
		30. Name and address of person wh	o completed cause of	death (Item 23a)							-	
	7		1010		111 5	Van	ACE BA	ANCH O	A Glon	Burn	nie Mazioso	
		31. Date filed (Month, Day, Year)		1-D - 70 trar's Signature	145	7-70	,		n ore	-011		
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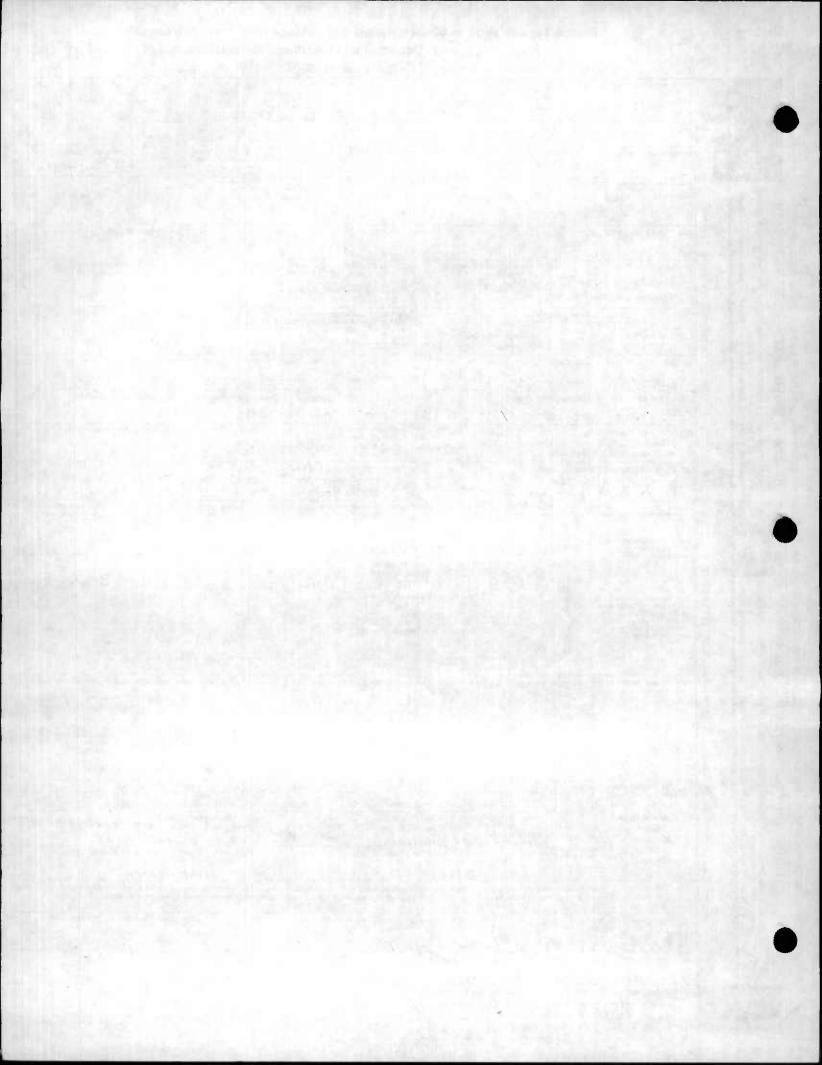
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						Cei	rtificat	e of	Death			Reg. No.		7404	
	Physician	1. Decedent's Neme	(First, Middle, La	st)							2. Date of De Month	eth Day	Year	3. Time of Deeth	
	/Medical	Micha	el L. Ma	aterkowsk	i	12					June		2000	08:10 A.M.	
	Examiner	4a Facility Name (If I				12			4b. City, To	wn, or Lo	cation of Death	4c. County	of Deeth		
		Sa	int Jose	eph's Med	dical Ce	enter			To	wson		Bal	timo	re	
	Funeral Director	5. Sociel Security Nur 164-38-36	- 1	Sex 7. ISM 2□ F	Age (In yrs. las	t birthdey) Yrs.	If Under Months	1 Yeer Deys	If Under Hours	Min.	8. Dete of Bird (Month, De June 13			plece (Stete or Foreign ntry) nsylvania	
		Usuei Residence of D			- 10						ounc =				
	f show fled at		106.County Baltimon	re	10c. City, 1	rown or Lo .dwin	cation							10d. Inside City Limits 1 ☐ Yes 2√ No	
100	or 28a-f show be notified at Director	10e. Streel and Numb			-1		10f. Zip					10g. Citizen of V		niry?	
- 1	arai arai		aid Cour			140.1		2101		11-0 (0-			SA	can Indien.	
020	Examiner must by Funeral	11. Meritel Stetus 1 □ Never Merriec 3 □ Widowed 4		12. Wes Deceded Armed Force 1 Yes 2 If Yes, Give Yeer or Dete	ss? ☑ No				Specify:		ecify Yes or No Rican, etc.)	Specify	ck, While,		
9 5	ted for	1	5. Decedent's Ed	ducation		16a, Deced	dent's Usu	el Occup	oation			16b. Kind of Br	vsiness/In	dustry	
Maryland 21215-0020	ygiene. It the Medical. Completed	Elementery/Second	only highest gradery (0-12)	College (1-4 +6		iiie. Ingine		se retire	during mos d)	it of worki	ng	Chemic	hemical		
0		17. Fether's Neme (F	irst, Middle, Last	)		, ,			18. Mothe	er's Neme (First, Middle, Maiden Sumeme)					
E 2	Mental h	Antonio	Mataulre	orralei.					De	a+h	Carne				
2		Antonio Materkowski Reath Carns  19a. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street and Number or Rural Route Number,									er City or Town	State Zii	n Code)		
Ma	7 is m traum												01010, 24	, 0000,	
0 :	permit. Pages 1 and Department of Health Important. If Item 27 any Injury or other to other.	20a. Melhod of Dispo		YOMBYT\ M.	20b. Pied	a of Dispo	sition (Ne	ne of		Jaraw	Dele	20c. Location -	City or T	own, Slete	
Baltimore,			Cremetion 3	Removel from Sta y)		ney V			m Gdn:	s 6-	-22-00	Timoniu	ım, M	id.	
Ball		21. Signature of Fund	eral Service Light	au l		22	Ruc	k To		Fune		me, Inc. Md. 2120			
		23a. Part1. Enter the shock, or heart	disease, or com	plications that cau	sed the deeth.	Do not ent					,		7-2	Approximete Interval Between	
a a	hycician	shock, or heart	failure. List dinly	one cause on eac	h line.									Interval Between Onset end Death	
	hysician /Medical	Immediate Ceuse (Fi	nel			^									
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3	in and hal-Irensit	al al		b	Frac			Ti	bia				1	3 weeks	
	g physician and as the burial-Irensit	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or In	litions, ediete		Due to (or e	s e consec	uence of):						1		
68760,	ician burie	cause. Enter Underly Cause (Disease or In	ring jury	c											
187	physicie is the bu	thet initieted events resulting in death) La			Due to (or es	s a conseq	uenca of):						i		
				d									1		
Box	or us			1444						al.					
		Pert II. Other significa	ant conditions o	ontributing to deet	h but not resultii	ng in the u	nderlying (	ause giv	en in Pert	l.	23b. Dld	tobacco uae co	ntribute t	to the cause of death?	
9	Ph dety										10	Yes 2ENo	3 Pro	obably 4 Unknown	
S,	signed bed by						1111						T	HIPLOGRAPH CONTRACTOR	
Records, P.O											24a. Wes	en eutopsy rmed?	ev ev	Vere autopsy findings veilable prior to ompletion of cause I death?	
I Re	age 2										1,027	Yes 2□No	1.	Yes 2 No	
	s certificate he director, page	25. Wes case referre	d to medical					-	26 Place	a of Deatl	(Check only o				
of Vita	s cent direct	examiner? 1X Yes 2 N		Hospitel: 1 Inp	ationt 2 VE	VOutpatier	t 3□ D	Oth	205			denca 6 □Oth	er (Snec	ihe)	
0	aral or T.T	27. Menner of Death		28a. Dele of (Month,	- 4 h	3b. Time of		28c. Inju Wo							
Division	at Director. After the in by the funeral Certification:	1 □ Naturei 2 ☒ Accident	5 Pending Investigation	unknow	n.	Injury	M		rk?  Yes 2.25	'No	subject	was in	autoi	mobile accident	
S	death.	3 ☐ Suicide	6 Could not b	about 3	Injury Al home, etc. (Specify)	n ITneu	eet, fector	v. offica			28f. Location (	3 weeks	per or Rui	ral Route Number,	
S S	Dir.	4 Homicide	Getermined	building			20, (4)				City or To	wn, Stete)			
Joenstei	within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	(Check only 2	☐ Certifying Ph	ysician: To the be	s of examinetion	dae deeth	occurred vestigetion	et the ti	me, dete er	od pleca,	and due to the	nknow cause(s) end me dete and pleca,	enner as	stated. to the ceuse(s)	
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P	1 2 3	29b. Signeture end tit	Neithed to e	. 1		,	29	o. Licens	se number			29d. Dete signe	ia (wonth	Day, rodri	
	1357	Atu	NI 1	1 VL	acli	Z.M.	0	0	.C.M.	E.		June	19.	2000	
1	0	30. Neme end eddres	s of person who	completed cause	of death (Item 2	3a) (Type,	Print)	1		h-1					
1	\	Stephen	5. 1	2aden7	2,	11	1 Per	n S	treet	, Bal	timore	Maryla	and 2	1201	
3	State	31. Dete filed (Month,	1		istrer's Signetur	0 6	1	,			A 38.01	-			
	Registrar	JU	N2 0 20	00	eperna	D	12/	ock	3						

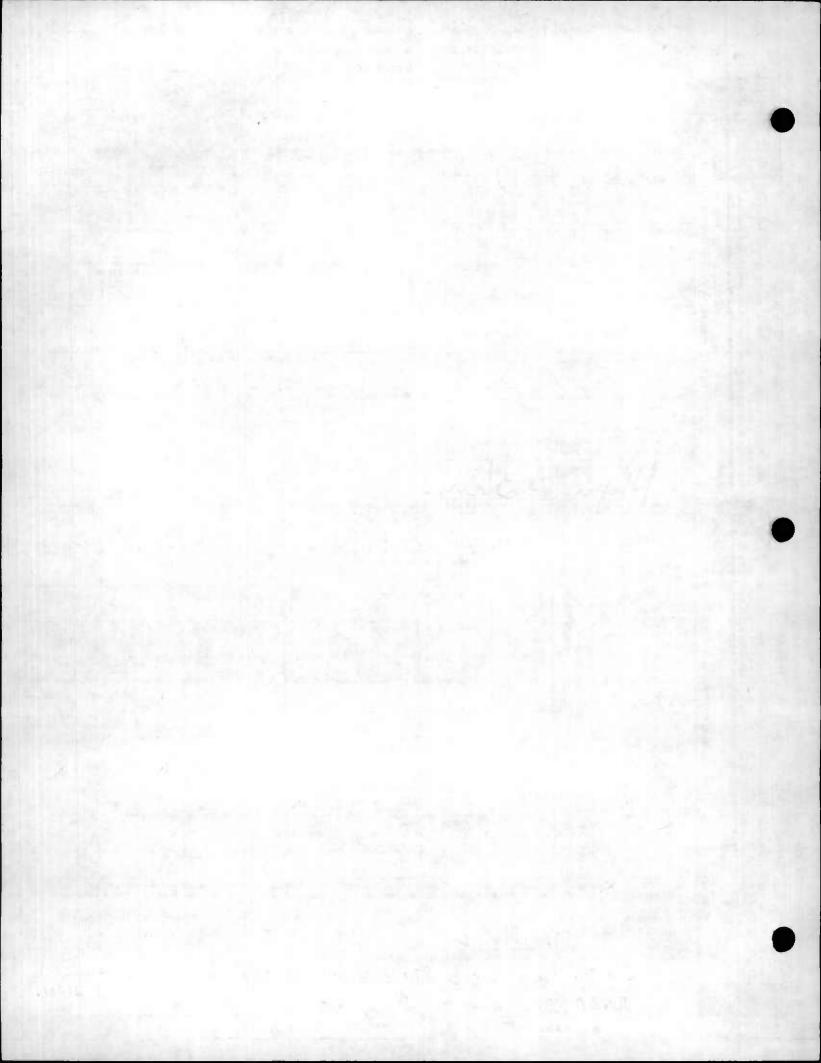


State of Maryland / Department of Health and Mental Hygiene 9455 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** James C. Morrissett, Sr. 17 4:30PM June 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1713 Summit Avenue Halethorpe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 12, 1917 9. Birthplaca (Stata or Foreign Country) Maryland 5. Sociel Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** Days Hours 11XM 2□ F Yrs. 82 Director 218-01-0193 Usual Rasidence of Dacedent 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits show 1 Yas 2 No Director Halethorpe 288-1 Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 238 1713 Summit Avenue 21227 United States Funeral Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) "natural", or flama 12. Was Decedent Ever in U.S. Armed Forcas? 2/15/45 1 ☐ Yas 2 ☐ No 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give 10/27/46 à 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) Elamantary/Secondary (0-12) College (1-4or 5+) Commerical 6 Steam Fitter 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) l and 2 should be fill seath and Mental H m 27 is marked oth Be William Morrissett, Sr. Katherine Rial Jermit. Pages 1 and 2.1.
Department of Health and important: If hem 27 is many injury or other page. 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 1713 Summit Avenue Halethorpe, MD 21227 Frances Lee Stecker (Daughter) 20b. Place of Disposition (Neme of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Meadowridge Memorial Park 6/21/00 Elkridge, MD 22. Nama and Address of Facility Ambrose Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licensal 23a. Part 1. Entar tha disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on each line. 1328 Sulphur Spring Road Arbutus, MD 21227 Approximata Intarval Between Onset and Death **Physician** Immediata Cause (Final disaasa or condition rasulting in daath) /Medical OF Examiner Due to (or as a consequence of): Examiner The law requires that the deeth certificate be executed burial-tran Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaase or Injury pue Due to (or as a consequence of): attending physician for use es the buria P.O. Box 68760, Physician/Medical that initiated events rasulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ▼ Yaa 2 No 3 Probably 4 Unknown signed t Records, by 24b. Ware eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 s 1 Yes 2₺ No certificate 1 ☐ Yas 25 No Division of Vital at or Attending Physician: T s after death. Il Director: After this certificat ed in by the funerel director, p 25. Was casa referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 🖾 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 70 1 Yas 2 No 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1XX Matural 5 Pending 1 Yes 2 No invastigetion 2 Accident 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, larm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a, Cartifiar 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end plece, and due to the ceuse(s) and mannar stated. 29b. Signature and title of certifian 29c. License number 29d. Data signed (Month, Dey, Year) RIDS D21716 June 20, 2000 erson who completed cause of death (Iten 23a) (Type, Print) polis Rd 4000 JUN 2 0 2000 32. State

Registrar

MIN S O S WILL

ITEM: #8	PER	F.H. 0					rtment o			na im	ental Hy	giene Reg. No.			
1. Decede	ent's Name	(First, Midd	le, Last) Inez	B.Mu	rray						2. Date of De Month 6	Day 18	2000	3. Time of 4:45	Death a.m
	y Name (II	not institutio	n, give street	and number	)			46	. City, Tow	n, or Loc	ation of Deal	h 4c. C	county of Deat	h	
		ood N					W 11-4 4 M		alti				N/A		
5. Social S			6. Sex		ge (In yrs. las 89	t birthday) Yrs.	Months D	ays	If Under 24 Hours	Min.		y, Year)		hplace (State ountry)	
	44-]	L 1 2 2 Decedent	-2 X	X	05	1					10-2	8-20	00	S.	С.
10a. State	_	10b. County				Town or Loc	cation	10						10d. Inside C	ty Limits
i M	d	F1	A\N		Balt	imore								1.X Yes	2 □ No
10e. Stree	et and Nun	nber					10f. Zip Co	de				10g. Citize	en of Whet Co	untry?	
	W_	Fran	klin :	Stree	+		21	20:					SA		
3 <b>X</b> I w	ever Marri	ed 2 Mar	ried 12. We	as Decedent med Forces' Yes 247 Yes, Giver ear or Dates:	Ever in U,S.		Ves Decedent Yes, specify	of His Cuban	panic Origi , Mexican,	n? (Spe Puerto F	cify Yas or No Rican, atc.)		I. Race - Ame Black, White Specify: B		
	(Speci	15. Deceder	it's Education	nleter()		I6a. Deced	ent's Usual O	ccupat	tion uring most o	of workin	ıa	16b. Kind	f of Businass/	Industry	
Elemen 6		ndary (0-12)	T	llege (1-4or	5+)	life. E	O NOT use n	etired)		Jina			-3/4		
	thgr	ade First, Middle,		N/A		Don	nestic		10 1404-1	e Name	(First, Middle		vate Ho	mes	
		Bruce									ne Di		orname)		
			hip (Type, Pri	int)		19h Mailia	n Address /St	traet e					Town, State, 2	in Corlet	
		racey		****									Md 2]		
20a. Meth	lurial 2		3 □Remova	al from State	COITI	e of Dispos	sition (Name of patory or other a Bap	of r place	)		Dete	20c. Loc	ation - City or		.c.
-	-	neral Service		310	uru	- M	Name and A arch 300 W	F/F	I Wes	st ven	ue Ba	lto,	Md 2	1215	
23a. Part	1. Entar th	e dispase, or t lailore. List	complication	s thet cause se on each I	d the death.	Do not ente	er the mode of	f dying	, such as ca	ardiac or	respiratory a	rrest,		Approximat Interval Bat Onset and	ween
Immediate disease of rasulting in the control of th	e Cause (I r condition n death)	Final 1	a	Athe	Due to (or a	Le Ro	tic G	aee	dio v	'લ્ટુલ	vlae c	lise	ase	yea	eg
Cause (D	ally list conding to im- nter Under isaase or I ed evants	nditlons, mediate rlying Injury	c		Dua to (or as										
Part II. Oth	n death) L		d		Due to (or as	e consequ	тепов от).								
Part II. Oth	ner signifi	cant condition	ons contribution	ng to death b	but not resultin	ng in the un	derlying caus	e give	n in Part I.		23b. Dld	tobacco u	se contribute	to the cause	of death?
1	Sema	entia									10	Yee 2	(No 3 P	robably 4	Unknown
											24a. Was	an eutops ormed?		Were autopsy available prior completion of a	0
												Man after		of death?	4
	aca rafar-	ed to medica							ne Dia	d Date	(Chart anti	1910	(40	1□Yes 2 X	No
axami	ner?		Hospita	l: 1 🗆 Inpati	ient 2 🗆 En	VOutpatien	3 004	Other			(Check only		Other (Spe	cifu)	
	r of Death		28a	Data of Inju		b. Time of		Injury Work	4 Nurs		8d. Describe			uly)	
1 25 N	atural ccident	5 Pendir investi		(Month, Di	ty Year)	Injury	М		? as 2 □ N						
3 □ S		6 Could determ	not be	. Place of In building, at	jury - At home tc. (Specify)	a, larm, stre	et, factory, of	fice		2	8f. Location ( City or To	(Street and wn, State)	Number or Ru	ural Route Nun	aber,
29a. Certi (Chec one)	k only	Certifyir	g Physician: Examiner: Or en	To the best the basis of d menner st	examination	dge, death and/or inv	occurred at the estigation, in a	ne time	e, date end nion, death	place, a occurre	nd due to tha d at tha time,	cause(s) a data and p	ind mannar as blace, and due	stated. to the causa(	5)
	alure and I	itle of certifie	are	blu	D				number 3 2   5	8		29d. Date	signed (Mont	h, Day, Year)	
	J.	yotin	Par 2000	khy 1	death (Item 23	8211		tai	v Stu	reel	- 8mi	te 40	7 Bal	Etimore 212	MB 01.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death dent's Name (First Middle, Last) 3. Time of Death Month Yea **Physician** 00 2000 /Medical 4b. City, Town, cation of Death Name (If not institution, give street and number) 4c. County of Death Examiner N/A As OKK Il Undar 24 Hrs. 5. Social Security Number If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) AUG 22 1927 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foraign **Funeral** Hours PENNSYLVANIA 1 M 2 K F 72 203203126 Usual Residence of Decedan 10a. State 10c. City. Town or Location 10d. Insida City Limits 10b. County 1 Yas 2 No Director BALTIMORE ROSEDALE 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Coda 1714 SUMMITT AVENUE 21237 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Rece - American Indian, Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Yaar or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Specify. 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SEAMSTRESS DRAPERY 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Be WALTER SHLIKAS MARGARET MALAKOSKIE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) J MAHON SR. / HUSBAND 1714 SUMMIT AVE BALTIMORE, MD 21237 GERALD 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 6/15/00 BALTIMORE, MD 21. Signature of Funanti Service License 22. Nama and Addrass of Facility CVACH/ROSEDALÉ FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Approximate Interval Between Onset and Death Immediata Cause (Final ACUN disease or condition rasulting in death) Due to (or as a consequance of): Examiner Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Dua to (or as a consequenca of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Waknown þ 24b. Wara eutopsy findings available prior to completion of causa of dasth? 24a. Was an autopsy performed? Completed t ☐ Yes 2000 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: No Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2000 P 28a. Dete of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - Af home, farm, streat, factory, offica building, atc. (Specify) 4 ☐ Homicida Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, and due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one) 29c. License number 29b. Signatura and fitie of certifier

State

**DHMH 16 Rev 6/95** 

Registrar

31. Data filed (Month, Day, Year)

30. Name and addrass of person who completed causa of death (Item 23a) (Type Print)

52. Registrar's Sig

Director

r than "natural", or flams 23a or 28a-f show the Medical Examiner must be notified at

the Maryland

filed within 72 hours after

Hygiene.

pemil. Pegas 1 and 2 should be filed with Department of Health and Mental Hygien, important: If item 27 is marked other try, any injury or other traumette.

**Physician** /Medical

Examiner

physician and s the burial-transit

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**page 2** certificate has

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Director: Alter

filled in by

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

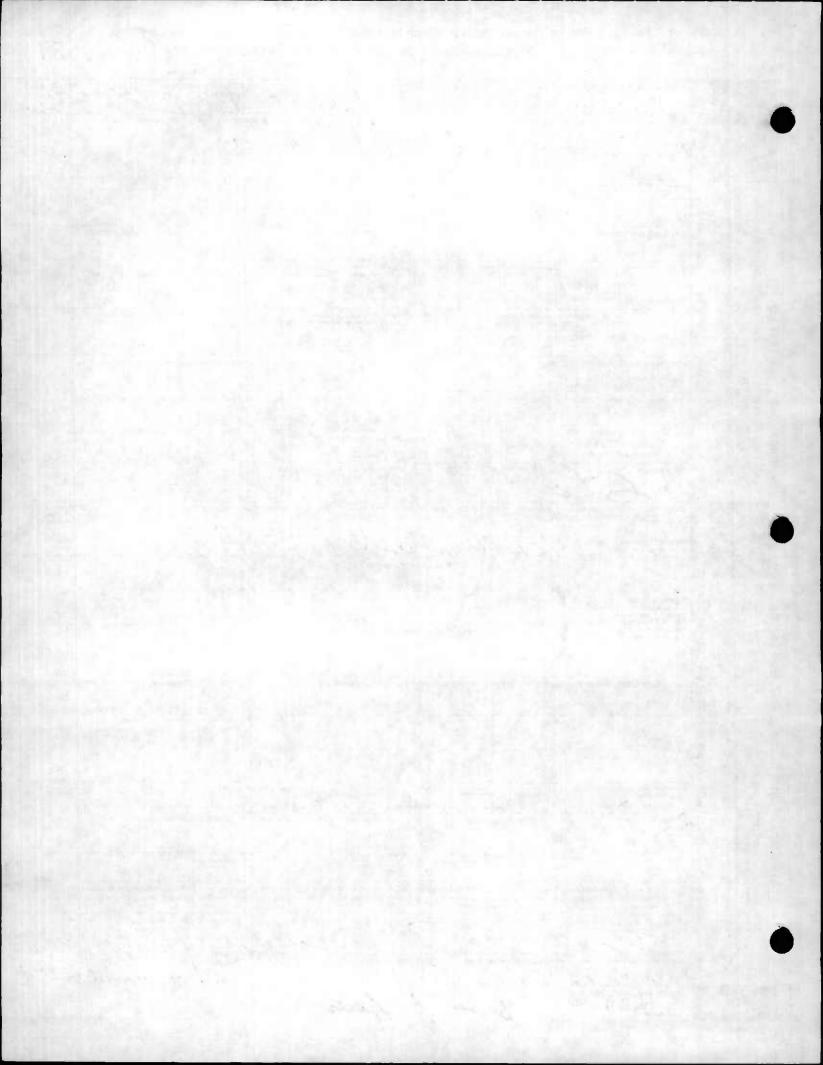
the signed by the

death certificate be assecuted

Box 68760.

Division of Vital Records, P.O.

Baltimore, Maryland 21215-0020



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 5 Year JOH N NICKENS 3,00 AM 23 2000 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death MARINER HEALTH OF NORTH ARUNDEL Glen Burnie Anne Arundel 9. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year 8. Date of Birth (Month, Day, Year) Nov 15, 1929 7. Age (In yrs. last birthday) Months Days Yrs 70 SC 250-38-9392 Usuat Residence of Decedent 10b Count 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 Hospital Drive 21061 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none janitorial apt complex 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) unk 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerome Nickens/son unk 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 NOther (Specify) in state S. Wade, Director 22. Nama and Address of Facility State Anatomy Board 655 W. Baltimore Street Ronald Baltimore, MD 21201 tant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, such, or heart failure. List only one cause on each line. Approximete Interval Between Onsat end Death tmmediata Causa (Finet disease or condition resulting in death) 6 WKC Due to (or as a ulmonary Due to (or as a consequence of) orguan Due to (or es a consequence qu) Dieele en a phera 23b. Did tobacco use contribute to the cause of death? Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed?

**Physician** /!:ledical Examiner

ettending physician and for use as the burial-transit

5

been signed by should be detac

cartificata

Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this cartificalety filled in by the funeral director;

To the Hosp within 24 ho To the Fune completely fi

The law requires that the deeth certificate be axecuted

P.O. Box 68760,

Records,

Division of Vitai

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

**Physician** 

/Medical

Examiner

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Director

Funeral

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Completed

**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hyglana.
Important: if item 27 is marked other than "natural", or hema 23s or 28s-f show principly or other treumade avant, the Medical Examine must be notified at Date.

Baitimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. molletus

completion of cause of death?

20 No 1 ☐ Yes 26. Place of Deeth (Check only ona) Other: Nursing Homa 5 Rasidence 6 Other (Specify)

28d. Describe how Injury occurred

1 ☐ Yas 2 ☐ No

25. Was case referred to medical examiner?

1 Yes 25 No 27. Manner of Death Naturat 2 Accident

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner stated. 29b. Signature and title of certified delivel

29c. License number D 029873 29d. Date signed (Month, Dey, Year) 5/23/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHANDELWALIMD

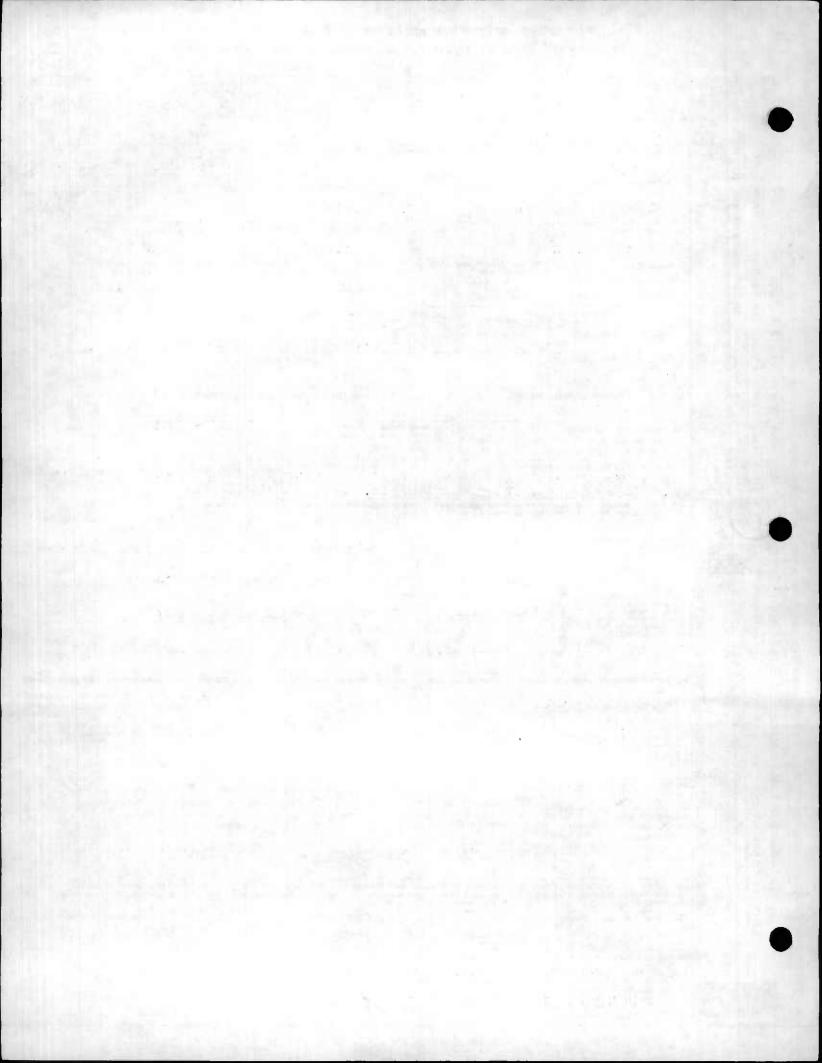
Hospital:

31. Date filed (Month, Day, Year) JUN 2 0 2000 32. Registrar'e Signature

1600S. CRAIN HUY, #201 GLEN BURNIE, Md. 21061

State Registrar

Darks



State of Maryland / Department of Health and Mental Hygiene 9459 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Day **Physician** 3:40 p.m. Jean B. Neifert June 18, 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 2701 Lockawana Street Adelphi Prince Georges If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 M 2 K F Months 86 June 5, Director 1914 Pennsylvania 166-16-6774 10d. Inside City Limits 10a. Stete 10c. City. Town or Location 10b. County 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Baltimore Rossville Maryland ž 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Barne 23a or 21237 9535 Shirewood Court United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Raca - American Indian Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Illed within 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 X No Specify: by Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Elementary/Secondery (0-12) College (1-4or 5+) Retail Salesperson 10 Baltimore, Maryland 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be III Iment of Health and Mental H Iant: If Isem 27 is marked off Be Mae Branning Jacob Rems 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Department of Health a Important: If Isem 27 is any Injury or other trau 2008. 9535 Shirewood Court Baltimore, MD Nancy N. Jones / Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 20e. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 6/22/00 Baltimore, Maryland Moreland Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road Misale Baltimore, MD 21214 LEONARD J. RUCK, INC. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onaet end Death **Physician** STROKE Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical 2 WEEKS Examiner Due to (or es a consequence of):
ATHEROSCUEROSIS 15 YEARS Examiner The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or es a consequence of): P.O. Pert If. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco was contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. Be Completed by 24b. Were sutopsy findings evailable prior to completion of cause of death? 24e. Waa an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No as or Attending Physician: The safer death.

Is after death.

In Director: After this certificate of in by the funeral director, page 100 pt. 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Residence Hospital: 1 Impatient 2 EP/Outpatient 3 DOA 1 Yes 2 No Medicai Certification: To 27. Menner of Deeth 28d. Describe how Injury occurred Injury et Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigetion 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a Lethe Funeral Completely filled 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pieca, and dua to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number D31563 30. Name and address of person who completed cause of death (ttern 23a) (Type, Print)

CHARLES M BENNER MD 11251 11251 LOCKWOOD DRIVE, SILVER SPRIKE 20901 CHARLES M

DHMH 16 Ray 6/95

State Registrar 31. Dete filed (Month, Dey, Year)

JUN 2 0 2000

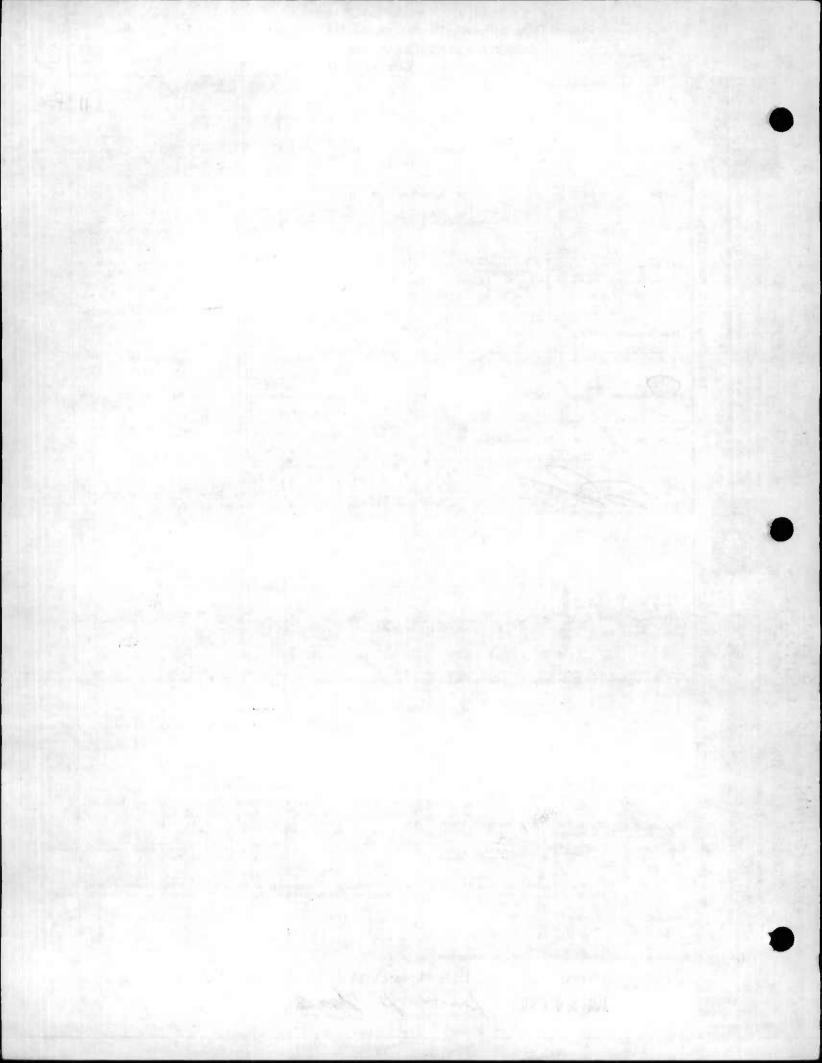
32. Registrer's Signeter

I'M So 15311 6.

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Deeth Month 17 Yaar **Physician** June Charles Neimiller 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Health Care/Rossville Baltimore Rosedale If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 158 M 2□ F Yes 85 Director 214-03-1378 10 - 1 - 14MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inaide City Limits 1 □Yas 2 □ No Director MD Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8014 Duvall Avenue 21237 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 Yea 2 No If Yes, Giva Year or Dates: 1 ☐ Never Married 2 M Merried 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busineas/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 Paint 0 Mixer 17. Father's Nama (First, Middle, Last) 18. Mother'a Nama (First, Middle, Maiden Surname) sermit. Pages 1 and 2 should be Department of Health and Mental William Neimiller Margaret Buumer 19a. Informent'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Hem 27 is other tra 518 Crisfield Road, Baltimore, MD Theresa Church/ Niece 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem 6-21-00 Baltimore, MD 21. Signature of Funeral Service L 22. Nama and Addrass of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue, Baltimore, MD 21237 23a. Part 1 Selectifia disease, or complications theil caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate toterval Between Onset and Death Physician Immediata Cause (Finat diseasa or condition resulting in death) /Medical Man CVI Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2/3 No 1 Yas 2 No carificate 25. Was casa refarred to medical examiner? 8 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 28b. Tima of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after deat Director: 6 ☐ Could not be determined 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide 24 hours Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. | Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Certifier (Check only one) within 2 To the P 29b. Signature and Tittle of certifing 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and addrass of person will completed cause of death (Item 23a) (Type, Print) MOHAMMAD RF2A BAHNAMA MANOR CARE 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State JUN 2 0 2000 Depera Registrar

DHMH 16 Rev 6/95

21403-137



State of Maryland / Department of Health and Mental Hygiene

ASP

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Data of Death Day Month Year **Physician** DOROTHY NICHOLSON T. JUNE 14 2000 1410 /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 805 RUSSELL AVE GAITHERSBURG MONTGOMERY H Under 1 Veer If Undar 24 Hrs. Birthpiece (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Hours Days Months 1□M 2MF Yrs 434-17-3448 43 Director 01/20/1957 TEXAS Usual Residence of Decedant with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits worde permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: if I fam 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, it is facilities. 1 XYas 2 □ No Director COLORADO GILPIN PINECLIFFE 10e. Street and Number 10f. Zip Coda 10g, Citizan of What Country? P.O. BOX 687 80471 USA Funerai 12. Was Decedant Evar in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxicen, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Meritel Status 1 Yas 2 No If Yes, Give Year or Detas: 1 Nevar Married 2 Married 3altimore, Maryland 21215-0020 1 Yas 2 No Specify Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ENVIRONMENTAL Elemantary/Secondary (0-12) College (1-4or 5+) CONSULTING CO. INDUSTRIAL HYGENTIST 4YRS 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumame) Be WILLIAM B. NICHOLSON BETTYE LOU DAVENPORT 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 687 PINECLIFFE, CO. 80471. WILLIAM B. BYNOG(HUSBAND) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Deta 1 ☐ Burial 2 ☐ Cramation XX Ramoval from State MONTELL CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 06/19/2000 MONTELL, TEXAS 21. Signeture of Funaral Sarvice Licansee 22. Nama and Address of Facility HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intarval Batween Onsat and Daeth **Physician** Immediata Cause (Finel diseasa or condition rasulting in daath) /Medical Subarachnoid hemorrhage Examiner Dua to (or as a consaguanca of): Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Ceuse (Disaase or injury that initiated evants resulting in death) Last pug the burial-tran Due to (or es a consequance of) Box 68760. signed by the attending physician d be detached for use as the buria Physician/Medicai Dua to (or es a consequence of): of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings availeble prior to 24a. Was an autopsy performed? page 2 should Completed Deed complation of cause of death? certificate hes 1X Yes 2 □ No 1 Yes 2 No Physician: 25. Was casa rafarred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) SCENE Medical Certification: To 1 Yes 2 No After this s after deeth.

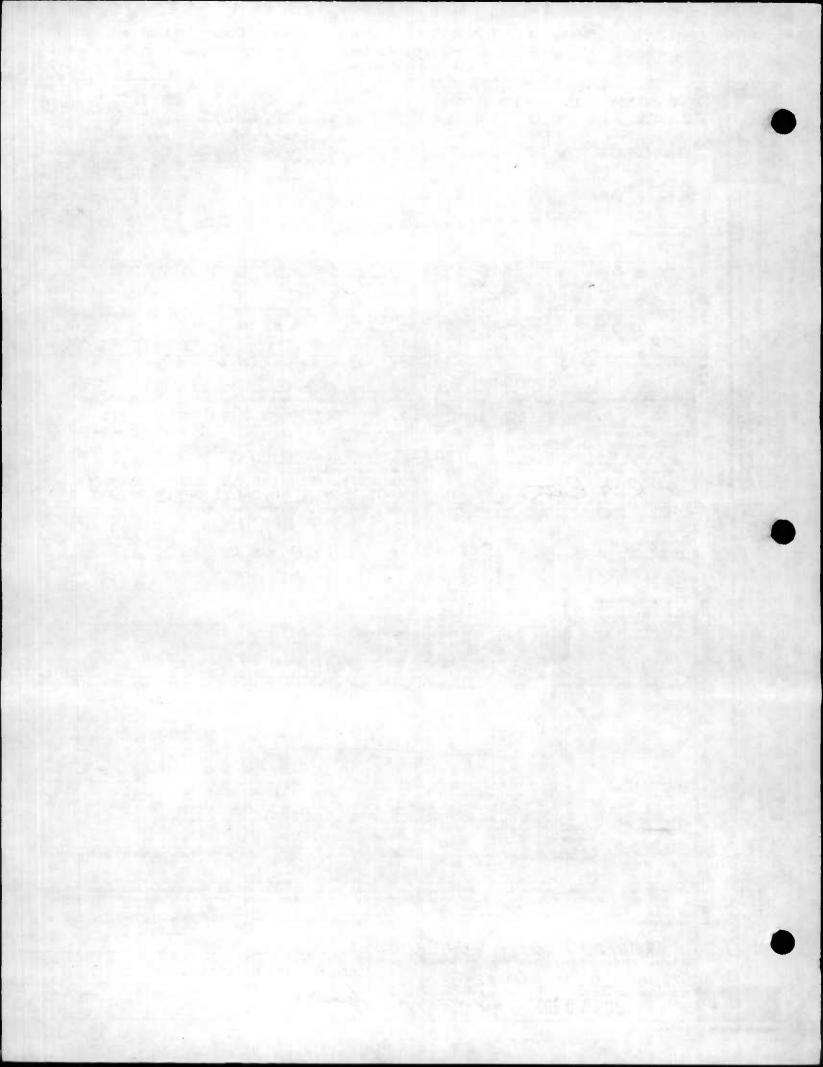
I Director: After this od in by the funeral d 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Neturel 5 Pending invastigation 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, straet, factory, offica building, atc. (Specify) filled in by 4 Homicida To the Hospital of within 24 hours at To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, deta and place, and due to the causa(s) and menner as stated.

2 Medical Examiner: On the basis of axaminetion and/or invastigetion, in my opinion, death occurred at tha time, deta and placa, and dua to the cause(s) and manner stated. 29e. Certifier 29d. Deta signed (Month, Dey, Year) 29c. Licanse number 29b. Signatura end title of certifier O.C.M.E JUNE 15,2000 30. Name and address of person who complated causa of death (Item 30 (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Radentz Strphen State

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31. Data filed (Month, Day, Year) 0 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Payne-Prewitt Georgie S. 19, 2000 5:20am June 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death NA Baltimore Joseph Ritchie Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 6. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 1□ M 2□ F Days 94 Yrs. 224-46-6454 05-05-06 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ØYes 2 □ No NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 USA 10 East Lee Street Apt. #802 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give X Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black 3.☐.Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Company Laborer 10th Grade 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blake Lucinda John W. Sharpe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 19a. Informant's Name/Relationship (Type, Print) 10 E. Lee Street Condo #802 Baltimore, MD Osborne Payne 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State VA 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal Imm State
4 Donetion 5 Other (Specify) Williams Mem. Pk. Cem. 06-21-2000 Roanoke 21. Signate of Funeral Service Licens 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part / Enter the diseasa, or combications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestion heart for: lun
Due to (or as a consequence of): 36 hors atrial fibrillat Internitlent Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? of the Alabeinen type, serile exist 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ■ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1403 pre Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 28d. Describe how injury occurred

**Physician** /Medical Examiner Examiner

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natural, or

permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy important: If Nem 27 is merited other any injury or other treaments event.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

27. Menner of Death 1 Netural 2 Accident

3 Suicide

4 ☐ Homicide

5 Pending investigation 6 Could not be determined

2000"

28a. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

8824 Winands

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29a. Certifier (Check only one)

29b. Signatura and title of cartifier Doye B. Jim . n. P.

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

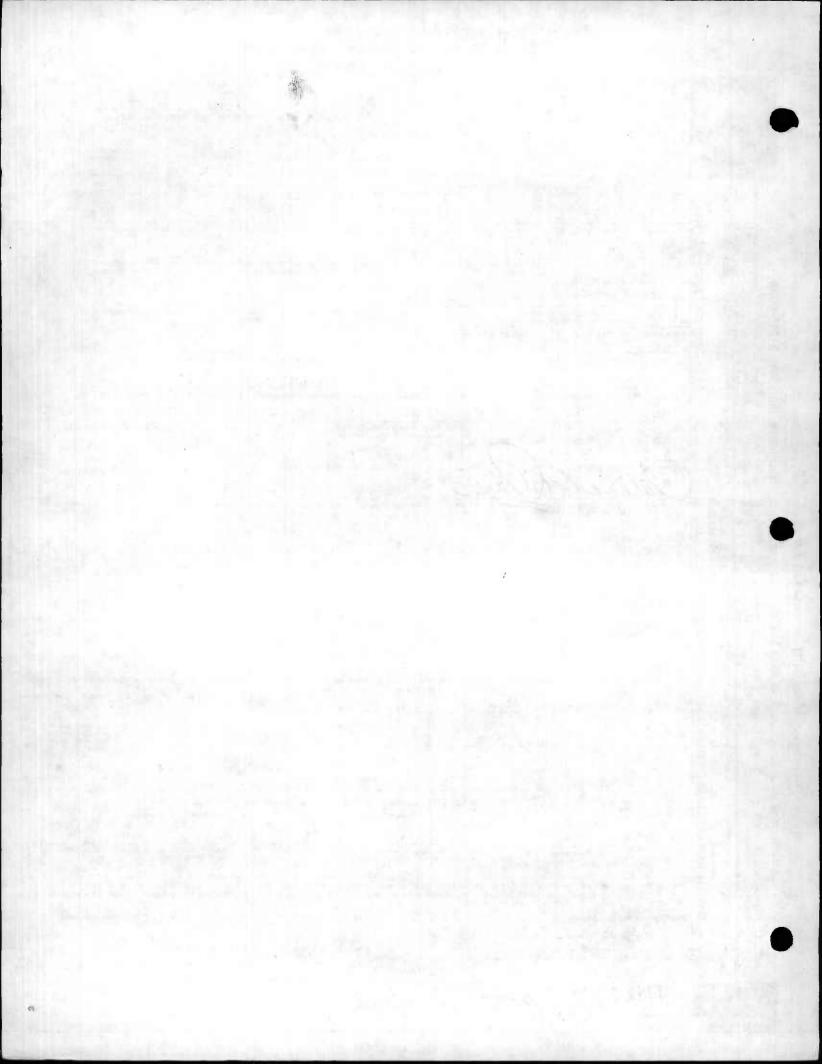
29c. License number Do 2175

Road . Randallstown , 12

29d. Date signed (Month, Day, Year) 6-19-00

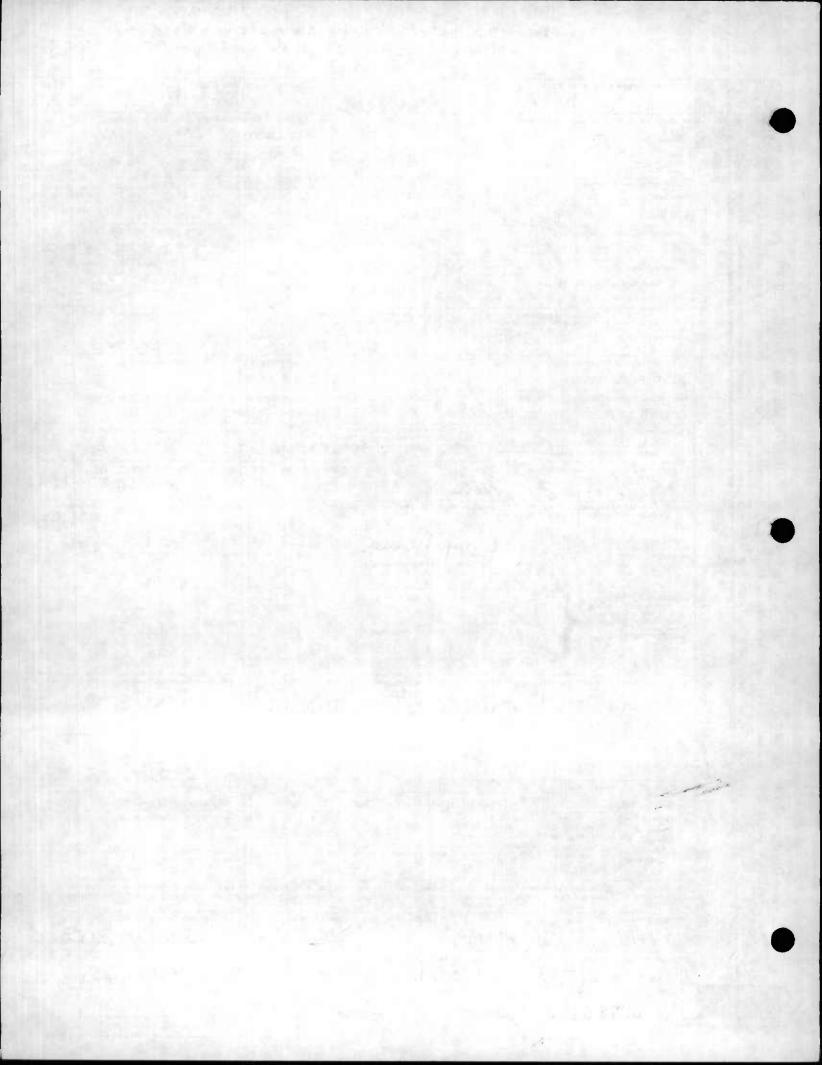
State Registrar Rolle B. FINN 32. Registrar's Signature

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State of Manuand / Department of He	alth and Mental Hygiene 0

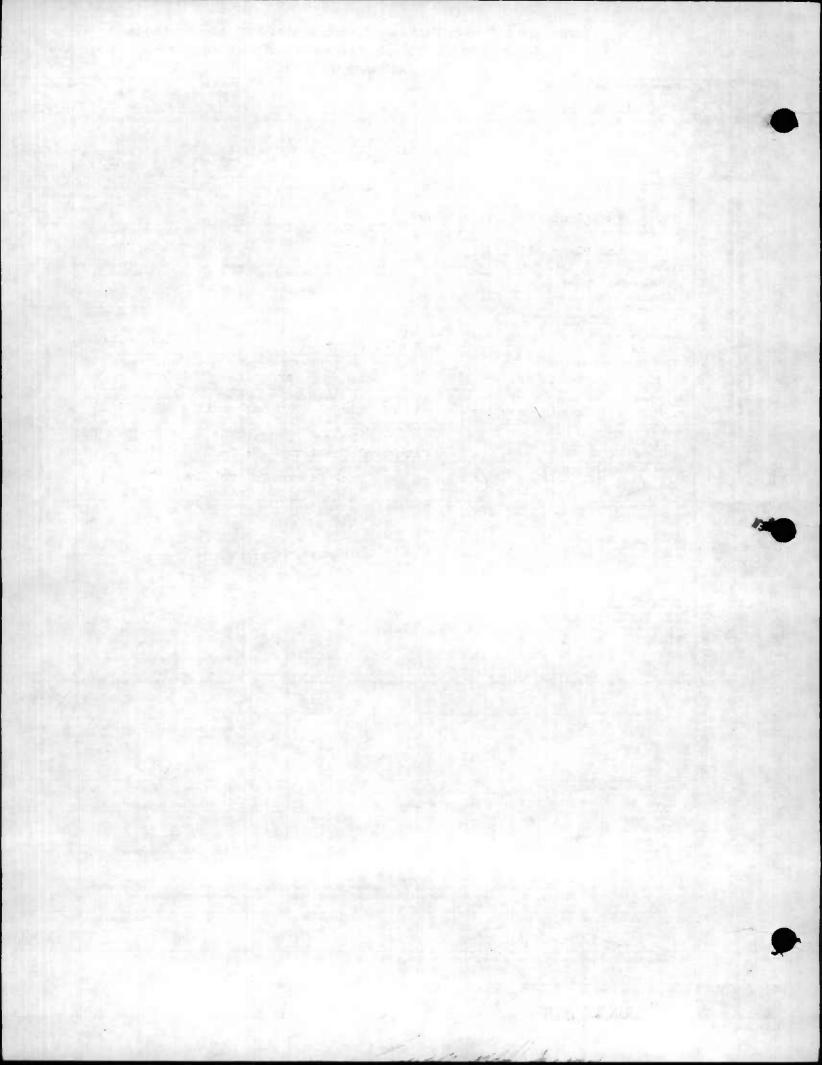
	Decedent's Name (First, Middle, Last)	Certificate	of Death	2. Date of De			3. Time of Death
Physician /Medical Examiner	Peter Nicholas  4a Facility Name (If not institution, give street and number)	Kreva	4b. City, Town, or				6:45 P.M.
	6401 Moyer Ave.  5. Social Security Number 6. Sex 7. Age (In yr.)	s. last birthday) If Under 1	Baltimo		rth	N/A	lace (State or Foreign
Funeral Director	212-22-4153 180 M 2□F 78	Mantha	Days Hours Min.	8. Date of Bi	5, 1922	Baltin	ore, Marylar
Mon W	Usuel Residence of Decedent  10a. State 10b. County 10c. 0	City, Town or Location			- 1	11	Od. Inside City Limits
oursed ector	Maryland N/A B	altimore 101. Zip 0	0-4-		10g. Citizen of V	The Court	1 Mayes 2 □ No
23a or	6401 Moyer Ave.		21206-1617		United St		
then 'natural', or hama 23a or 28a-f show the Medical Examiner must be notified at ompleted by Funeral Director	11. Marital Status  1 Never Married 2 Merried  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Pyes 2 No W.  11. Was Decedent Ever in Armed Forces?  1 Pyes 2 No W.	W.II 13. Was Decedent Yes, specific 1 Yes 2	ent of Hispanic Origin? (S fy Cuben, Mexican, Puert No Specify:	pecity Yes or No o Rican, etc.)	o- 14. Race Bled Specify	e - Americ k, White, c : Whi	etc.
	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	life. DO NOT use		king	16b. Kind of Bu		Teda
If them 27 is marked other than or other traumatic event, the second other traumatic event, the second other traumatic event, the second other traumatic event, the second other traumatic event, the second other traumatic event, the second other traumatic event, the second other traumatic event, the second other traumatic events of the second	17. Father's Name (First, Middle, Last) Nicholas P. Prevas	Restau			, Meiden Surnam	Servi	ce
7 le me traume	19a. Informant's Name/Relationship (Type, Print) Mrs. Maria Prevas Angelos(Daughter)		(Street and Number or Run Mill Road Ba				Code)
Important: If frem 27 any injury or other tr once.	20e. Method of Disposition 20b.	Place of Disposition (Namcemetery, crematory or off	e of her place)	Date 5/22/2000	20c. Location -	City or To	
Important: any injury pncs.	21. Signature of Funeral Service Licensee L. Ga	22. Neme and	Address of Facility Rux	ck Towson 50 York Ro	Funeral Ho d. Towson,	ome, I Md. 2	nc. 1204-2515
sician	23a. P. 1. Intel the disease, or complications at caused the despect, or heart failure. List only one cause on each line.	eth. Do not enter the mode	of dying, such as cerdiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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2 2	Cause (Disease or injury that initiated events resulting in death) Lest	(or as a consequence of):					
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I director	25. Was cese referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐ DO/	26. Place of De		one) sidence 6 □Oth	er (Specif	y)
After the funeral	27. Manner of Death  1 Acident  28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	Bc. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occur	red	
where the function states of the this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	a Could not be	home, ferm, street, factory, cify)	office		(Street and Numb own, State)	er or Rura	l Route Number,
Ne Funera pietely fille edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examination and manner stated.						
To the comple	29b. Signeture and title of certifier	29c.	License number		29d. Date signe		
11	· Curles (raget tu)		D15546		June	19,2	2000
541	30. Name and address of person who completed cause of deeth (Its CUANTES W.), 5(20) Loc	on 23a (Type, Print)	Blue, Bal	filmore	all, co	212	39
State Registrar	31. Date filed (Month, Day, Year)  32. Registrer's Sign	nature L					



State of Maryland / Department of Health and Mental Hygiene

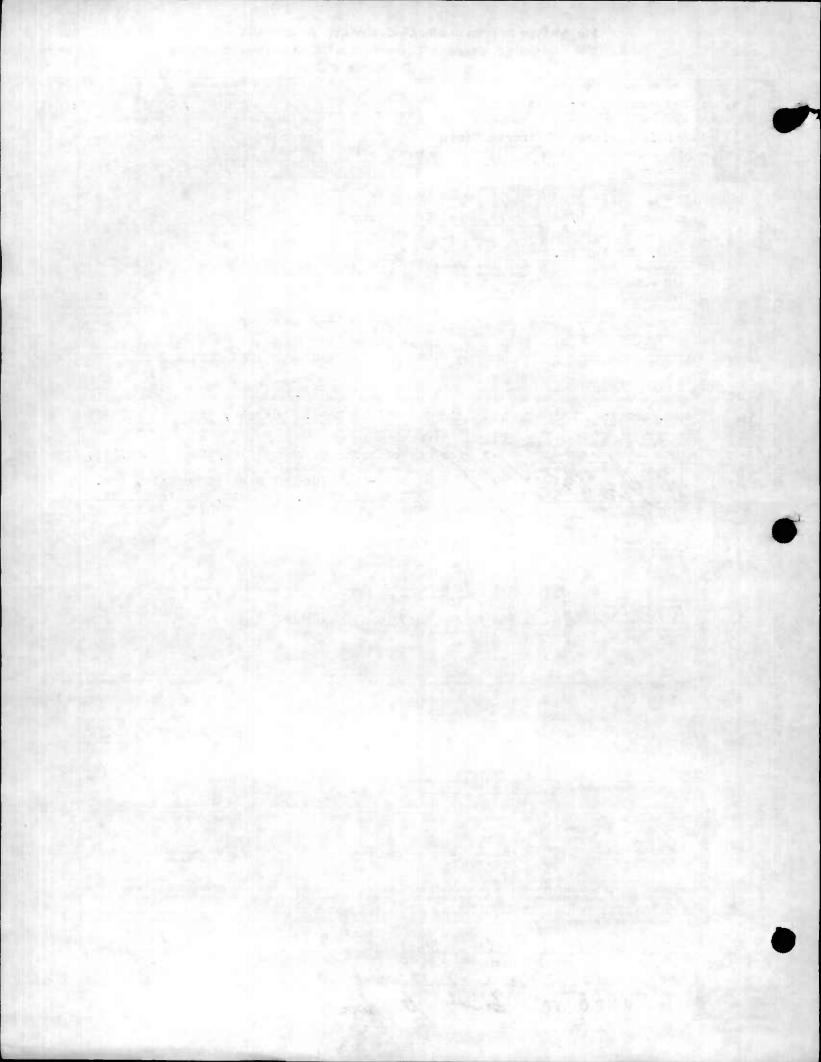
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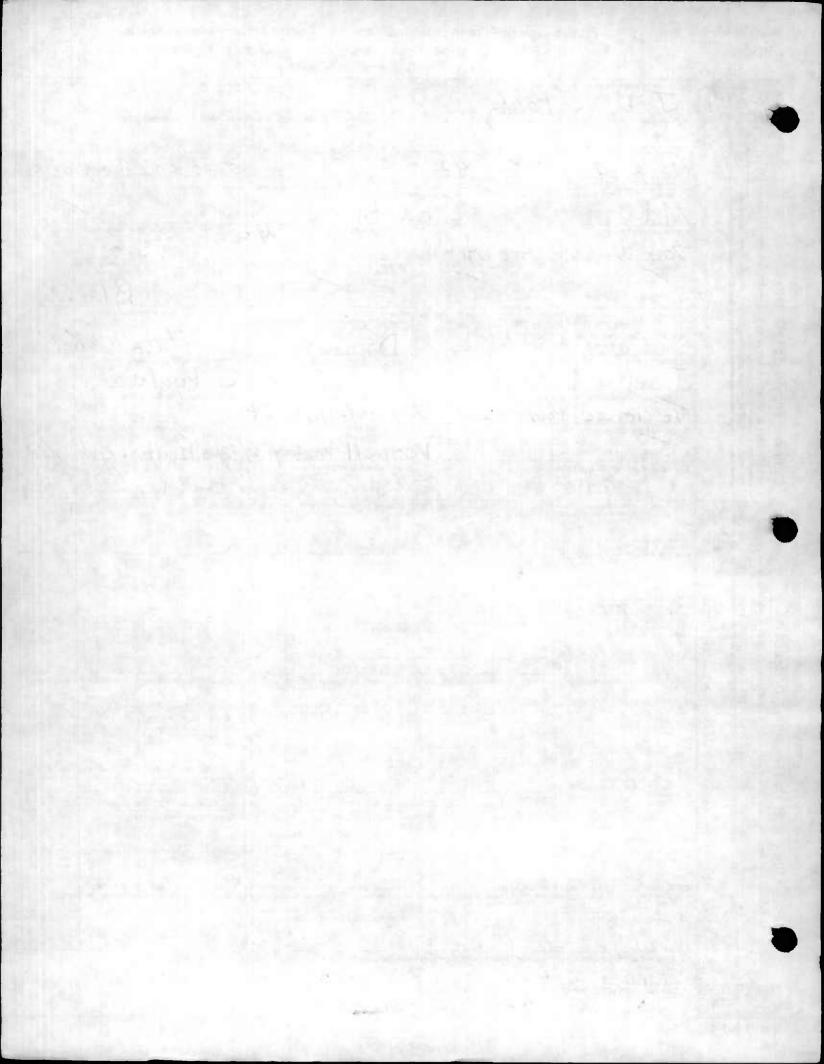


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	Genesis He  5. Social Security N			ge (In yrs. las		If Under 1 Yeer	Dunda		Date of Birth		ltimo	
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											,	1 ØX es 2 □ N
	Maryland	N/A		Balt	imoı	ce City						
	10e. Street and Nu	mber				10f. Zip Code			1	0g. Citizen (	of What Cou	untry?
	524 N. Cha	arles St.				21201				JSA		
1	11. Marital Status		12. Wes Deceder Armed Forces	?	1	<ol><li>Wes Decedent of I If Yes, specify Cub</li></ol>	Hispanic Origii an, Mexicen, I	n? (Specifi Puerto Ric	y Yes or No- an, etc.)		Re <i>ce -</i> Amer Black, White	
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			Removal from Stet	Cen	netery, c	cremetory or other pla	ice)		Date	ZOU. COURTIC	MI - City Of I	own, State
	The second secon	5 Other (Specify		Gaze	ens	of Faith	Cemete:	ry 6/	19/200	00 Ro	ssvil	le, Maryla
	21. Signature of Fa	peral Segriculicer	m ()	/	-	22. Name and Addre Ouda-Ruck		1 Now	o of T	Leban	le Tre	
	1 m	4/11/	took	/								
	23a. PartT. Enter t	he disease, or com	plications that caus	ed the death.	Do not	7922 Wise enter the mode of dyl	ng, such as ce	erdiac or n	espiretory arr	est,		Approximate Intervel Between
	SHOCK, OF Hea	it lelidle. List only	one ceuse of each	III 10.								Onset and Death
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	resulting In death)	"	a			sequence of):						
5			No	PRE							III C	
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Physician/M	Pen II. Other signii	icant conditions o	ontributing to death	but not result	ing in th	e underlying ceuse gi	ven in Part I.					to the causs of dea
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d Dy									24e. Wes a	n eutopsy	24b. V	Ware autopsy finding
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Sel unicanoli.									d. Describe h	ow injury oc	curred	
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	4 Homicide	determined	28e. Plece of building,	njury - At hom etc. <i>(Specify)</i>	ne, farm,	street, factory, office		281	City or Tow	treet end Nu n, Stete)	<i>imber</i> or Hu	ral Route Number,
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I	one)	TO MODIO	and manner		711 011 000	mroongunon, mmy	opinion, dodin		and and		ACC LEG	
	29b. Signature and	title of certifier				29c. Licen	sa number	20	2	29d. Date sig	gned (Month	h, Day, Year)
	100	Achda.	7, 5,0	1 1	MA		2718	7		6/1	6/00	2
	30. Name and addr	ess of person who	completed cause of	death (Item 2	23a) (Ty	pe, Print)		A		01	0100	-1-4
	Carin	1000 I	151011	7	11	0.000- 4	1 ou	3	alti	aren	MD	21222
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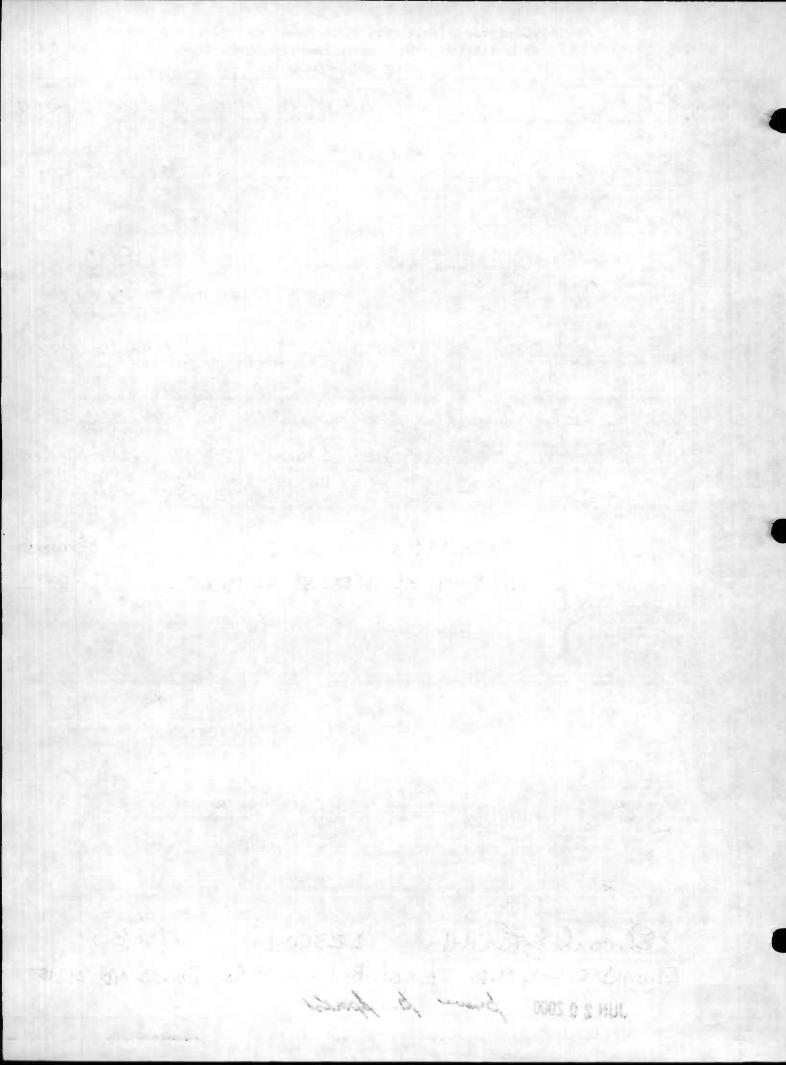


	K.S		LE AMEND ITEMS:	State of Ma	arylan	d / Depart	ment of	Health a	and Me	ental Hy	giene	1	9468
JO	ANNA PO		LE 1. Decedent's Neme (First, Middle, La		, 4/	Certi	ficate of	Death	- 1	2. Date of De			3. Time of Death
2.	Physician	n	JANNA	Pople						Month JUNE	Dey 15, 200	Year	0643 AM
<b>5</b> %	/Medica Examine	_	4a Facility Neme (If not institution, giv	a street and number)				4b. City, To	wn, or Loc	ation of Deati			0010121
			700 WEST NORTH				If Under 1 Yea		IMORI			0.0145-1	(0)
	Funeral Director		5. Social Security Number 6. S	M 20F	42		Months Deys		Min.	B. Data of Bir (Month, Da		9. Birthpi	aca (State or Foreign
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death with the Maryland	f show		10a. Stete 10b. County		TOC. City	R C	time	100				10	od. Inside City Limits  1
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ath with	23a c		700 W. North	Ave.	40+	B					US	A	
	New The state of t	runeral	11. Marital Status  1 ☑ Never Married 2 ☐ Merried	12. Wes Decedent   Armed Forces?		S. 13. Was	s Decedent of es, specify Cui	Hispanic Original Mexican	gin? (Spec n, Puerto R	ify Yes or No ican, etc.)	14. Rece Biec	- America k, White,	
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21215-0020 d within 72 hours af	'natural', or Nema 23a or 28a-f show addeal Examinat must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)		16a. Deceden (Give kin	nt's Usual Occu and of work done NOT usa retir	upation e during mosi	t of working	9	16b. Kind of Bu	sinass/Ind	ustry
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Rec e la w	10 C	2	that your also		10							of c	death?
Division of Vital Records, or Attending Physician: The law requires ti	certificate hes rector, page 2		25. Was case referred to medical			L. CU.		28 Piace	of Death	(Check only	Yes 2□No	1,12	Yes 2□ No
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O LIG	wher the		27. Manner of Death  12 Neture 5 Panding	28a. Dete of Injur (Month, Day	Year)	28b. Time of Injury	28c. Inj	ury at ork?	28		how Injury occurr		
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	al Director: After ted in by the funeral		4 ☐ Homicida determined	building, etc	. (Specify	)	,,	2.01		City or To	wn, Stete)		
Hospit	within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  Madical Cartification: To Re Com	a l	(Check only 2X) Medical Exam	ysician: To the best of niner: On the basis of	axaminat	vledge, death od ion and/or invasi	courred et the tigation, in my	time, date en opinion, dee	d plece, ar	nd dua to tha	causa(s) and ma date and piaca, a	nner as st	ated. tha causa(s)
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An Article   Property   Secretary   Property   Proper		Physicia	n	1. Decedent's Name (First, Middle, Last	1	D -				Yaar	ime of Death
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Secretarian   Secretarian		Examine	er "	5300 G1	1	UE	1		40. Obditty	NIA	
Company   Comp	1	Funeral			x 7. Age (In yrs. la	st birthday) If Under 1 Year	If Under 24 Hrs.		'ear)	9. Birthplace (S	State or Foreign
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Season of the proposed parts completed in the contribution of th		urs a	þ		1 ☐ Yes 2 ØNo If Yes, Give			licen, etc.)	100		LK
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Physician / Modical Examiner    Part   Display   <u>—</u>	ZQ = 2 A		1 Con	1.100	2140 N.	FULTON.	AVE. R	PALTO,	MD. a	21217	
disease or condition southing in death)  Due to (or as a consequence of):  Sequentially list conditions, and suppose of the su	F	Physician		23a. Part1. Enter the disease, or comp ahock, or heart failure. List only o	ications that caused the death. ne cause on each line.	Do not enter the mode of dyi	ing, such as cardiac or	raspiratory arras	t,	Inten	/al Between
Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate conditions, if any, leading to immediate conditions, if any, leading to immediate conditions, if any, leading to immediate conditions, if any, leading to immediate conditions, if any, leading to immediate conditions or included the conditions of any o				disease or condition	. Metasto	atic Ca	ncer			-5	Sweet
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Cause (Diseases or Influy) The composition of the c		outed ransit	amir	Sequentially list conditiona,	b. Due to (or	as a consequence of):	951 Ca	NCEL			
The state of the second property of the secon	60,			if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c						
DO YOU TO YOU THE PROPERTY OF	687	phys the	9	that initiated events	Due to (or a	as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23b. Did tobacco use contribute to the cause of death   1   Yes 2   2   2   2   2   2   2   2   2   2	XO	onding use a	2		d						
24a. Was an autopsy performed?  24b. Were autopsy finding performed?  24c. Was an autopsy performed?  1		death he atte	sicle	Part II. Other significant conditions co	ntributing to death but not result	ting In the underlying cause gi	ven in Part i.	23b. Did tob	ecco use cor	ntribute to the o	cause of death?
24a. Was an autopsy performed?  24b. Were autopsy finding performed?  24c. Was an autopsy performed?  1	Δ.	d by the detect	P S					1 Yes	2   KNQ	3 Probably	4 Unknown
25. Was cese referred to medical axaminer?    Yes   25 No	ds,	signe ld be	d b					24a. Was an	autopsy	24b. Were au	topsy findings
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25. Was cese referred to medical axaminer?    1		The is	E O					1 Yas	20No	1 ☐ Yes	No No
1   Inpatient   2   ER/Outpatient   3   DOA   4   Nursing Homa   5   Rasidence   6   Other (Specify)    27. Manner of Death   1   District   2   Accident   3   DOA   4   Nursing Homa   5   Rasidence   6   Other (Specify)    28. Date of Injury   M   1   Yes   2   No   North, Day Year   28. Time of Injury   M   1   Yes   2   No   28. Location (Street and Number or Rural Route Number, City or Town, State)    28. Place of Injury - At home, farm, street, factory, office   28. Location (Street and Number or Rural Route Number, City or Town, State)    29a. Certifier (Check only one)   29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.  29b. Signature and title of certifier   29c. License number   29d. Data signad (Month, Day, Year)    27. Manner of Death   1   Data signad (Month, Day, Year)   28d. Date of Injury - At home, farm, street, factory, office   28d. Describe how injury occurred   28d. Describe how	Vita	clan: entifica ector,	Be	axaminer?	Jacobski			(Check only one)			
12   Accident   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier   29a. Certifier   29a. Certifier   29a. Certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29c. License number   29d. Data signad (Month, Day, Year)	of	L Sign		TO THE ZORINO	1   Inpatient 2   E	HVOutpatient 3LJ DOA	4 LI Nursing Horr				
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Data signad (Month, Day, Year)	ion	oding th. : After e fune	at lo	19 Natural 5 ☐ Pending	(Month, Day Year)						
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Data signad (Month, Day, Year)	VIS	er des rector by th	t C	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	2	81. Location (Stre City or Town,	et and Numb State)	Per or Rural Rou	te Number,
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Elward & Leeus 123601 6/2000		within To the	Me	29b. Signature and title of certifier	. 0	29c. Licen	se number	290	d. Data signa	d (Month, Day, 1	Year)
30. Nama and addrass of person who complated cause of death (flem 23a) (Type, Print)	9	1		Edward	& heelth				6/20	200	
		70		30. Nama and address of person who co	implated cause of death (Ilem	23a) (Type, Print)		A D	A. ~ -		~:~
30. Nama and addrass of person who completed cause of death (Nem 23a) (Type, Print)  EDWARD J. LEE, M.D. ZYOL W. Belvedere Ave, BALTO AD ZIZIS  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		Stat	0	31. Date filed (Month, Day, Year)	32. Registrar'a Signatu	to w. Ise	nedere	une p	HC TO	2 db	1512
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Registrar DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 19470 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Year 4 Am **Physician** VEENON JUNE 2000 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Keswick Nursing Care Center Baltimore

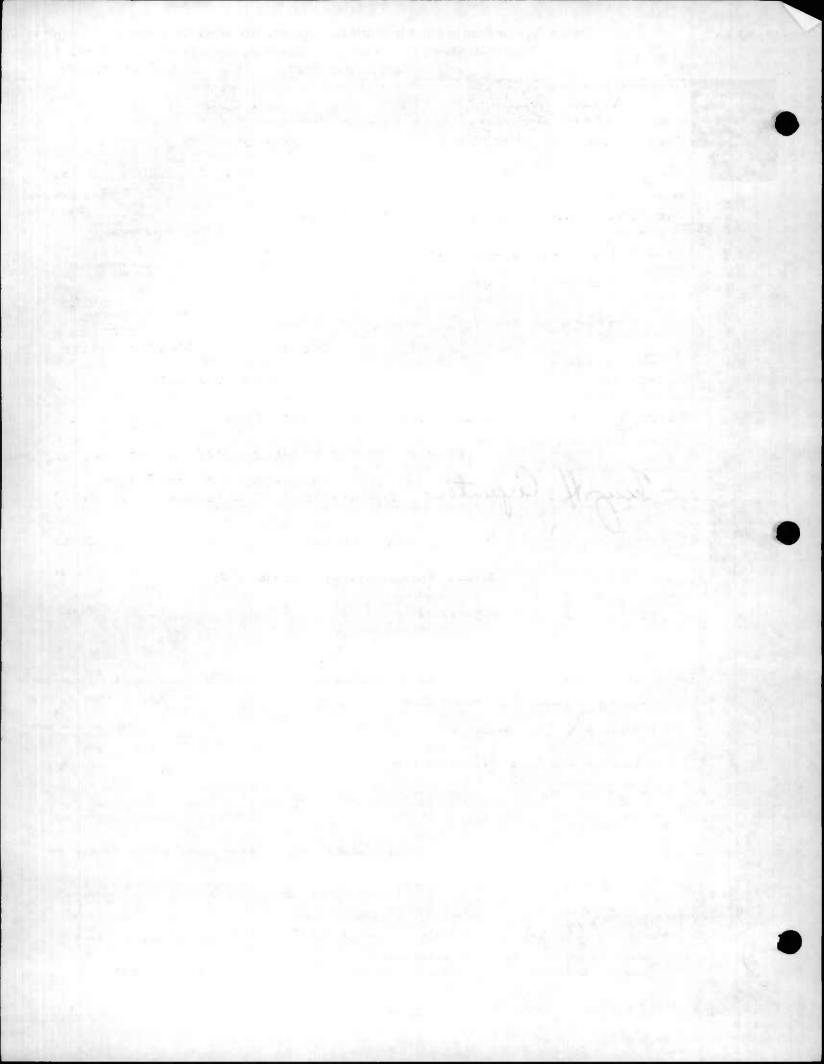
If Undar 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) If Under 1 Yeer 5. Sociel Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months 1 2 F Days Director 213-10-2705 93 Nov. 28,1906 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location nem 27 is marked other than "naturel", or items 23s or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director ¥EVes 2□No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3838 Roland Avenue Apt. 211 21211 Funeral Wes Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Dacadent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. 1 Yes PNo If Yes, Give Yeer or Datas: 1 ☐ Nevar Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes X No Specity: à Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decadant's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mentel other. Mass Transit Elementery/Secondary (0-12) College (1-4or 5+) Printing Office Administration 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middia, Meiden Sumema) Be Joseph Rill Minnie Davidson 19a. Informant's Name/Raletlonship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21211 Clara E. Rill Wife 3838 Roland Ave. Apt. 211 Baltimore, MD 20e. Mathod of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) Deta 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Baptist Cemetery 6/22/00 Upperco, Maryland 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. Part Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one caused an aech line. Approximata Interval Batween Onset and Death **Physician** Immediate Ceusa (Finel disease or condition resulting in daath) /Medical CENGESTIVE HEAZT FAILURE 2425 Examiner Due to (or as a consequenca of): Examiner 10 425 (CA36 I Scheme CAZDIOMYOPATHY attending physician and for use es the buriel-transit certificate be executed Sequentielly list conditions, if eny, leading to immadiate cause. Enter Underlying Causa (Diseese or Injury that initieted avants rasulting in deeth) Last Due to (or es a consequance of): ZAYRE Box 68760 HYPEZTENC, UN Physician/Medical Dua to (or as a consequence of): P.O. I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Phenodary Fizzasis 72° Amodiazone Records, þ 8 24b. Wara autopsy findings available prior to HTPEZTMYZUS ? 2° ANODOZINE Completed 24e. Was an autopsy completion of cause of death? COLON ( SESECTES) 1994) CALL. NOWA OF 1 ☐ Yes 2 XNo After this certificete 1 ☐ Yes 2 No Division of Vital 25. Wes case raferred to medical Be 26. Placa of Death (Check only one) Othar: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA P 1 Yes 2 No 27. Menner of Daeth 28a. Dete of Injury (Month, Dey Yeer) 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred al or Attending P s efter deeth. Il Director: After t od in by the funera Medical Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homleida To the Hospital o within 24 hours of To the Funeral DI completely filled in 29a. Cartifiar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signatura and title of cartifle 29d. Data signed (Month, Day, Year) 29c. License number 12399 mustant JUNE 19, 200 30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print) 700 W. 40 ms. CHARLES O'DUDYAN IF, MY KESWICK BALTIMUZE, my 31. Date filed (Month, Day, Year) 32. Ragistrer's Signeture State

DHMH 16 Rev 6/95

Registrar

JUN 2 0 2000



#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Zachary Martin William Rickell JUNE 10 2000 15:06 /Medical 4c. Obunty of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Agnes Hospital Baltimore If Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State Country) | April 22,2000 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 27 120 M 2□ F Yrs Director 217-57-4990 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits I be filed within 72 hours after death with the Marylan ntel Hyglene. ed other than "natural", or flerna 23a or 28a-f show ent, the Medical Examinar must be notified at 1 Yes 2 No Maryland Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1051 Bulman Harbor 21122 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If frem 27 is marked othe eny injury or other traumatic event, pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Gary Rickell 2 Jennifer Hearin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary & Jennifer Rickell(Parents) 1051 Bulman Harbor Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial Park | 6/22/00 Glen Burnie, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne, MD 21227 23a. Part1. Enter the disease, or comshock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Metabolic Aculosis Immediate Cause (Final disease or condition resulting in death) /Medical Examiner as a consequence of): YSCOC(4/ SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. Subaruch Mold Hemorrhage 23b. Did tobacco use contribute to the cause of death? 0.0 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? Extreme prematinty 24a. Was an autopsy performed? Completed 2 □ No 10 Yes 2□ No Division of Vital 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Deal 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1.2Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation after death 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide A 24 hours Dir ö

State Registrar

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29a. Certifier

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29b. Signature and little of certifier

31. Date filed (Month, Day, Year)
JUN 2 0 2000

30. Name and address of person who com

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r: On the basis of examend manner stated.

bleted cause of death\_(frem 23a) (Type, Print)

32. Registrar's Signatu

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

DAVID A FRISHBERG ST. AGNES HEALTHEARE GOOCATON AVE BALTIMORE, MO

mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

JUNE 19, 2000

21229

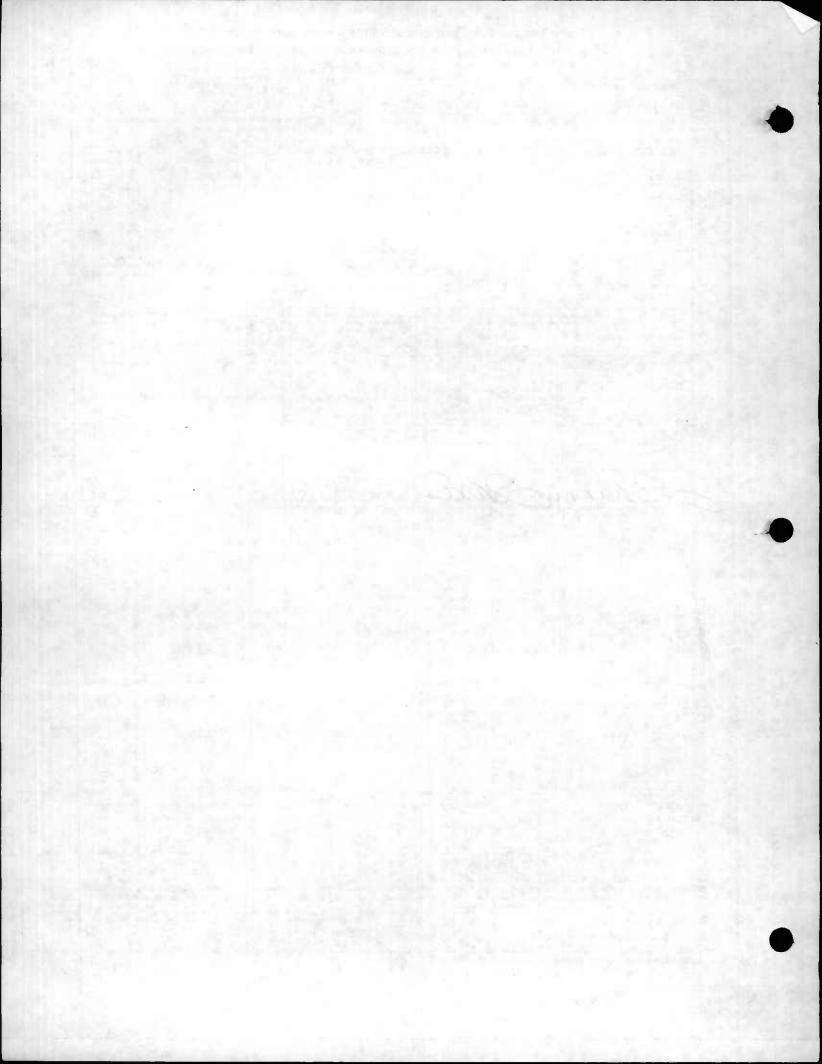
#### Piease Type or Print in Biack Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene n Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** RANDALL VERNON 12:10 AM 2000 06 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 24 Hrs. 8. D Bon Secours Hosp. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) | ff Under 1 Year 6. Sex 1 M M 2 □ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours Director 219-26-2457 Usual Residence of Decede 09 M.D the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Show "natural", or items 23s or 28s-f show Yes 2 No Directo MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Raca - American Indian, Black, White, etc. 2107 Windsor Ave 21217 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Merried 2 Married 21215-0020 Specify: Black 1 ☐ Yes 2 X No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th grade na Auto Mechanic Self Employed 7 is marked othe traumatic avant, Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be filment of Health and Mental Health and Mental Health and I is marked off Charles F. Randall Alma Lewis 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 7 2 0 7 6 19a. Informant's Name/Relationship (Type, Print) 105 Buck Beaver Dr., Jacksonville, a of Disposition (Name of Madelyn Phillips-Daughter 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removel from State Department of Important: If any injury or 6/16/2000 Marriottsville, Md Crestlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funerel Service Licensee 22. Neme end Address of Facility March F/H West 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 21215 Approximate Interval Between Onset and Death Physician BRONCHIAL ASTHMA Immediate Cause (Final /Medical MINUTES disease or condition resulting in death) Due to (or es a consequence of) Physician/Medical Examin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): use as the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? PULMONARY OBSTRUCTIVE DISEASE Yss 2 No 3 Probably 4 Unknown 9 CHRONIC þ Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed MELLITUS DIABETES The law 1 Yes 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient ≥ ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Attending Neturel 5 Pending investigation death. 1 Yes 2 No 2 Accident or Attand after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completaly filled Hospital 17 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piace, end due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number julka 6-16-00 D26395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSPITAL BALTIMORE MD BON SECOUR JULKA MiD. SURJIT 5. 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State

JUN2 0

Registrar

**DHMH 16 Rev 6/95** 

2000



00-3337-510 ibm UNK. 00-155

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kevin Sanders Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Das Sanders Physician Kevin Camont 4b. City, Town, or Location of Death 2000 4c. County of Death 20:28 PM /Medical 4a Facility Nama (If not institution, giva street and number) Examiner NIA 1900 RIDGE HILL STREET If Undar 1 Year 8. Deta of Birth (Month, Dey, Year) Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 MM 2□ F 062-58-139 Usual Rasidence of Decedant 29 Yrs Director NEW JUNE 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NIA BALTIMORE 1 X Yas 2 No MARYLAND Directo Name 23a or 25a-f 10f. Zip Coda 10e. Street and Number 10g. Citizen of What Country? 1).S.A 2021 KIDGEHILL Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxicon, Puerto Rican, etc.) 14. Race - American Indian, Biack, Whita, atc. 11. Maritai Status hours after ☐ Yas 2 No I Yas, Giva 1 Navar Married 2 Married 8 Maryland 21215-0020 1 Yas 2 No Specify. Specify: BLACK 3 Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within 72 al Hygiene. Elementary/Secondary (0-12)

IRTH GRADE College (1-4or 5+) CONTRACTING COMPANY IMPROVEMENT 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Mental 8 JO- ANNE SANDERS Pages 1 and 2 should UNKNOWN of Health and N Item 27 is ma 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) ASHAWN STEVENSON BROTHER 1812 N. BLNTALOUST, BALTIMORE, MD Q1216 Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Date 20c Location - City or Town, State Department of I 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 8 106-21-2000 LANSDOWNE, MARYLAND Mt. ZION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility JOSEPH H. BROWN JR. FUNERAL HOME Q140 N. FULTON AVE., BALTI MORE, MARYLAND 21217 Approximata Intarval Between Onset end Death 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laeding to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760 Physician/Medicai the Dua to (or as a consequance of) 980 signed by the a Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4) Unknown of Vital Records, by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to Completed complation of causa of death? certificate has 2□ No Yas 2□ No Attanding Physician: 25. Was cesa rafarred to medical axaminar? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Yas 2 No this luneral 27. Manner of Deeth 28a. Deta of Injury (Month, Day Year) 28b. Tima of Injury 28d. Dascribe how injury occurred 28c. Injury et After 5 Pending invastigation Division 1 Netural 2024 HM 281. Location Street and Number or Rural Routa Number. City or Town, State) 1900 Rudge Well 15/0 1 Yas s after death death 2 Accident the 6 Could not be 3 ☐ Suicida 28a. Piece of injury - At homa, tarm, streat, factory, office building, atc. (Specify) 6 4 Homicida 6 Treet To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. Licansa number 29d. Deta signed (Month, Day, Year) OCME JUNE 16, 2000 30. Name and addrass of person who completed cause of the

State Registrar **DHMH 16 Rev 6/95** 

THEUDORE MAKIN 31. Date filed (Month, Day, Year) JUN 2 0 2000

32 Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

(Item 23a) (Type, Print)

**ORIGINAL** 

JUN 2 0 2000 James James

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

9474 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** Inez Simmons 14, June 2000 2:20pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 704 N. Eden Street Baltimore If Undar 24 Hrs. 8. D 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days Hours Months 1□M 2□F 245-54-0859 68 03-05-32 Director NC Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show avant, the Medical Examiner nust be notified at MD NA 1 ☐ Yes 2 ☐ No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with or items 23s or 704 N. Eden Street Funeral 21205 IISA . Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes X No Specify: Specify: Black Aq 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) IOth Grade College (1-4or 5+) Domestic someone else home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Be Pages 1 and 2 should be in nent of Health and Mental I int: If item 27 is marked or Unknown Simmons Florine Powel1 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra page. James Simmons 704 N. Eden Street Baltimore, Maryland 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetert 06-19-2000 Lansdowne, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee WM.C. March FH 1101 E. North Avenue Mosmon 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Medical Immediate Cause (Finel syndrome (MDS Myelodysplastic
Due to (or as a consequence of): disease or condition resulting in death) Examiner Examiner The law requires that the deeth certificate be asscuted ettending physician and for use as the bunal-tren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed by þ of Vital Records, 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of causa of deeth? After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No al or Attanding Physician: T s after death. Il Director: After this certifical ed in by the funerel director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital c 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier pletely 29d. Date aigned (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number ME Brods

DHMH 16 Rev 6/95

State Registrar 242

1650 OF leaps St Balt MO 21231

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

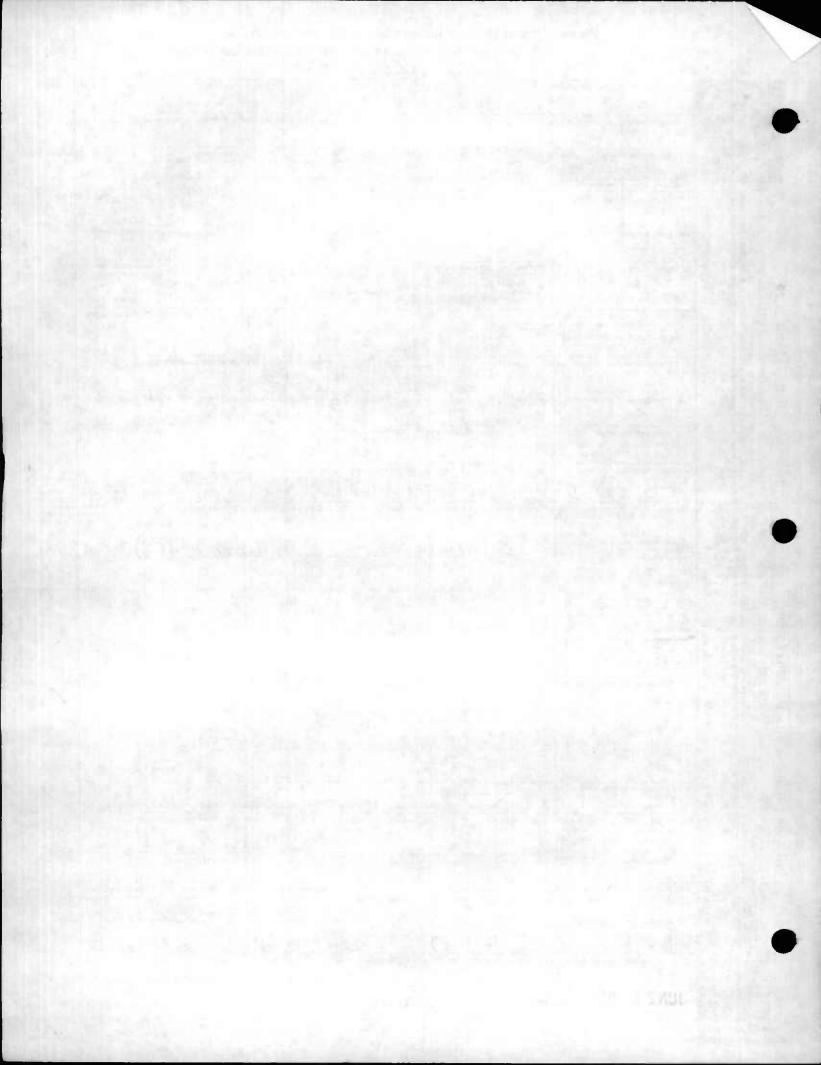
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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Physician JUNE 18 2000 MILDRED DOROTHY 12:35 P.M /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH OF FOREST HILL HARFORD FOREST HILL If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Nov. 18,1914 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 X F 85 Vrs Illinois Director 350-12-9004 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frems 23s or 28s-f show treumside event, the Medical Examinal must be notified at 1 Yes 2 No Director MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 813 Milford Mill Road 21208 14. Race - American Indien, Black, White, etc. Funeral 11. Merital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filled within 72 hours after of Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or then any injury or other traumatic event, the pages. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 N Merried White 1□ Yes 2 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest Turner Ester Rose Heyer 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren L. Smoot (Husband) 813 Milford Mill Road, Pikesville, MD 21208 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stale 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Cemetery 6/21/00 Sykesville, Maryland 22. Name end Address of FacilityLoring Byers Funeral Directors, Inc 21. Signeture of Funerel Service License 8728 Liberty Road, Randallstown, Maryland 21133 alper 23a. Pert / Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in death) M-di-Due to (or as a consequence of): Examiner Physician/Medical Examiner The law requires that the deeth certificate be executed attending physician and for use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Box 68760. that initieted events resulting in death) Last Due to (or as a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contributs to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 Yes 2 No 1 Yes 2 No certificate Vital Hospital or Attanding Physician: 24 hours after death.
Funeral Director: After this cartificately filled in by the funeral director, g B 25. Wes case reterred to medical 26. Place of Death (Check only one) Other: 4 Nutraing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 1 | Inpatient 2 | ER/Outpalient 3 | DOA Division of 27. Mannes of Death 28a. Dele of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 June 20, 2000 D3551 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

State

Registrar

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31. Dete filed (Month, Day, Year)

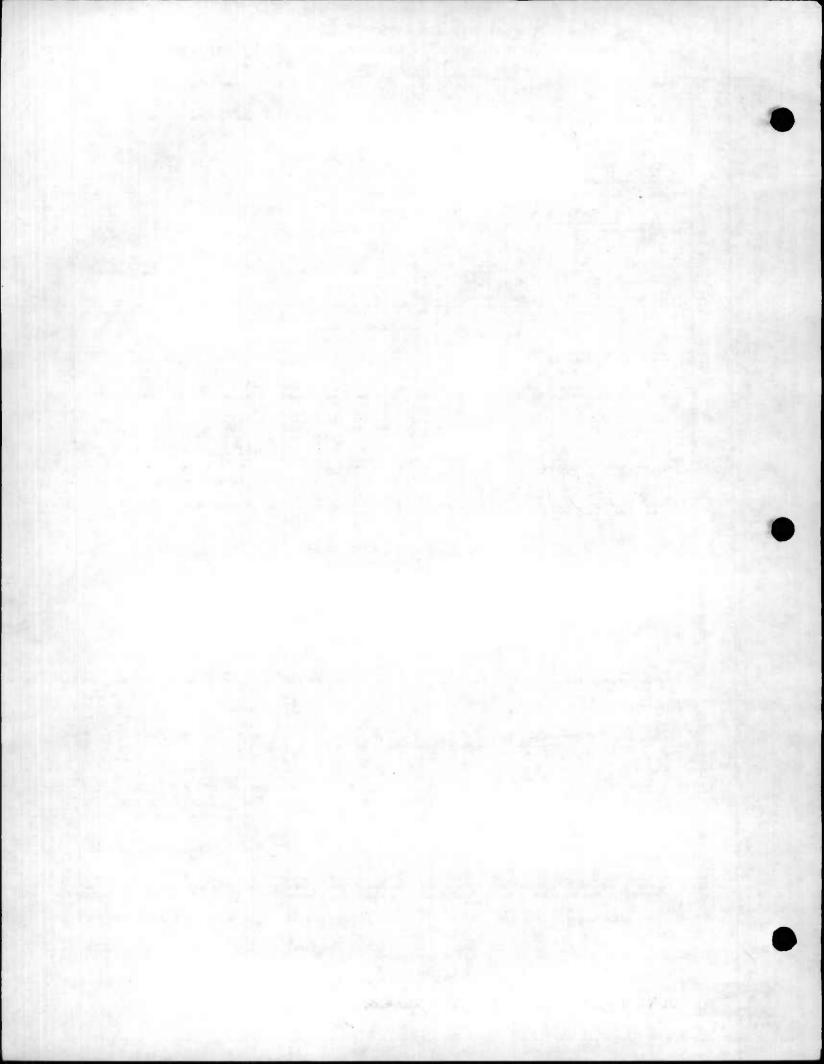
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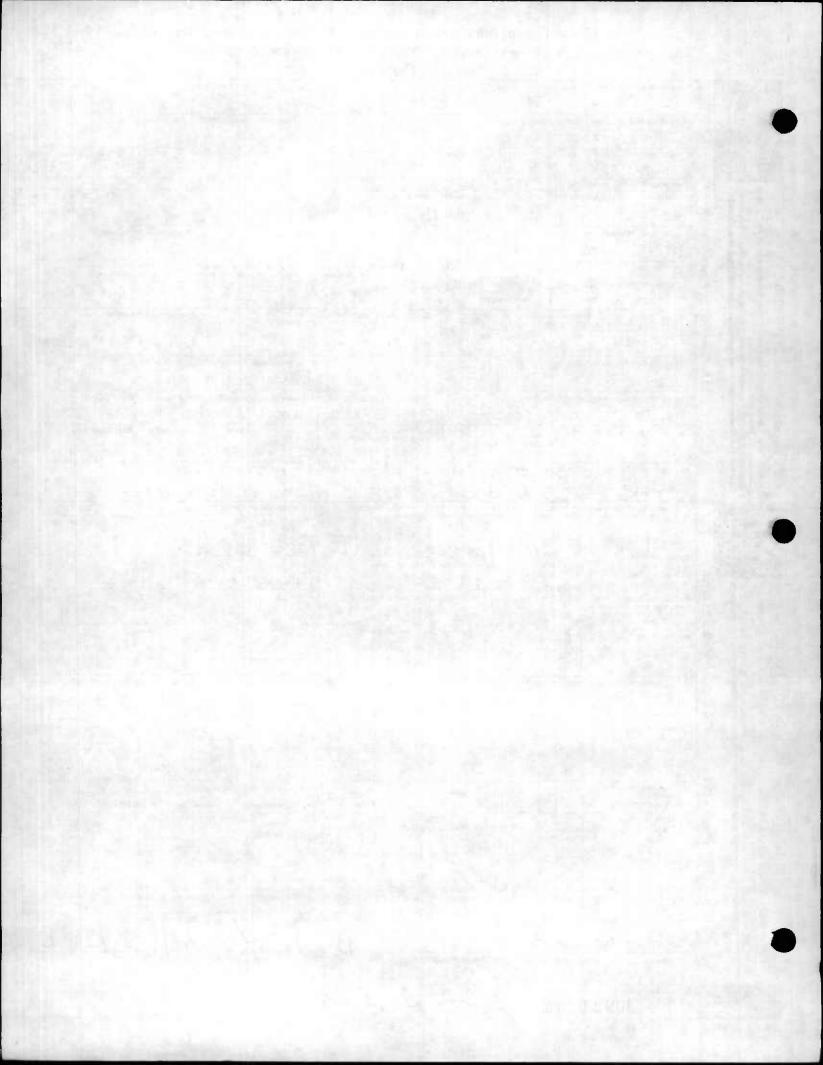
32. Registrer's Signature



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 1 1 1 7 6

						ficate of	Death		Reg. No.	1	3470		
	Physician	1. Decedent's Name (First, Mi Robert		Shann	non		2. Date of D June		Day Wass		3. Time of Death 10:40 AM		
	/Medical	4a Facility Name (If not institu					4b. City, Town, or I						
	Examiner		ritan Hosp	•			Baltimo						
	Funeral Director	5. Social Security Number 230-82-1525	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da NOV - /	, 1954	9. Birthp Coun Vorth	lace (State or Foreign try Carolina						
2 .	1	Usual Rasidence of Decedent 10a. State 10b. Cou	nty	10c. City, 1	Town or Loca	tion				1	Od. Inside City Limits		
	to to	MD N/A Baltimore									1) Yes 2□ No		
- 1	e not	10e. Street and Number				10f. Zip Code	120		10g. Citizen of V	What Coun	itry?		
-	rel ral	6118-TC Faird			U.S.A.								
21215-0020	ursi', or items 23e or 25e-t show al Examiner must be notified at d by Funeral Director	11. Marital Status 1 □ Never Married 2 🛣 N 3 □ Widowed 4 □ Divord	H Vac Give	XNo		is Decedent of Horses, specify Cub	dispanic Origin? (S an, Mexicen, Puert Specify:	pecify Yas or No o Rican, etc.)		e - Americ ck, White, : Whi	etc.		
200	dical		lent's Education hest grade completed)		16a. Deceder (Give kir	nt's Usual Occup	pation during most of word)	king	16b. Kind of Bu	usiness/Ind	dustry		
121	Mental Hygiene. Tried other than helbur rite event, the Medical. To Be Completed	Elementary/Secondary (0-1)		or 5+)		NOT use retire lesman	d)		langlev	Ente	erprises		
CA 2	Co nt and	17. Father's Name (First, Midd	le, Last)		34	1 Coman	18. Mother's Nar	ne (First, Middle	, Maiden Surnam		o. p. 1303		
Maryland	o sed	Peter Ross					Barbara						
ary	T THE	19a. Informant's Name/Ralation	onship (Type, Print)		19b. Mailing	Addrass (Street	and Number or Ru	ral Route Numb	er, City or Town,	State, Zip	Code)		
	27 le	Mrs. Della Sha	nnon- Spouse		The state of the s		el Avenue	Baltim	ore, Mar	ylan	d 21206		
Baltimore,	ment of He ant: If Ren ury or oth	4 □ Donation 5 □ Other		Hill	top Se	ion (Name of tory or other pla rvice C	orp.	Date 5/19/00	20c. Location -	, Mar			
Ball	on and and and and and and and and and an	21. Signature of Funeral Service Licensee Heather Cain  22. Name and Address of Facility Leonard J. Ruck, Inc.  5305 Harford Road Baltimore, Maryland 21214											
70		23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,  Approximate Interval Between Onset and Death  Immediate Cause (Final disease or condition rasulting in death)  Due to (or as a consequence of):											
rĈ.	hysician /Medical .xaminer												
	اةِ السَّادِ		12.00	Annho	ithm	iA	1						
68760,	physician and is the bunal-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):											
90,	olan a ourial-												
68760,	physic the p	that initiated events rasulting in death) Last		Due to (or as	s a conseque	nce of):	4 4 4 7 9						
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Box	d for a	Part II. Other eignificant cond	en in Part I	23h Did	tohacco use co	ntribute to	the cause of death?						
cords, P.O. Box	igned by the attending physician and be detached for use as the bunal-transit by Physician/Medical Examir	Faith. Other dignificant cond	mone continuing to death	Tout not resulti	ing in the und	erlying cause gr	veri in Part I.		Yes 2 No	3 proi			
Records,	s been s 2 should pieted								an autopsy ormed?	av:	era autopsy findings allable prior to mplation of cause death?		
	page 2							10	Yes 200	10	Yes 20 No		
/ita	certificate rector, pa	25. Was case referred to med examinar?					26. Place of Dea	ath (Check only	ona)				
of the	this call direct	10 Yes 2□ No	Hospital: 1 Inpe		P/Outpatient	JEI DUA		_	idence 6 Oth		y)(y)		
no	After funer	27. Manner of Death	Oliving .	Day Year)	8b. Time of Injury	28c. Inju Wo		28d. Describe	how injury occur	red			
DIVISION Of VITAL  To the Hospital or Attending Physician: T within 24 hours after death.  To the Funeral Director: After this certificat completely filled in by the funeral director, p	al Director: After the in by the funeral Certification:	3 Suicide 6 □ Cou		00 Classification 44 have 6 as about 6 at a 46						28f. Location (Street and Number or Rural Route N City or Town, State)			
	n 24 hours he Funeral pletely filled edical C	29a. Certifier (Check only one) Certifier (Medic	ying Physician: To the besi ai Examiner: On the basis and manner	of examination	edga, death o n and/or inves	ccurred at the til stigation, in my o	me, date and place opinion, death occu	, and due to tha rred at tha tima,	causa(s) and ma data and place,	annar as s and dua to	tated. o tha cause(s)		
Toth	To the	29b. Signature and title of cert	fier 4/ ,			29c, Licens	se number	1	29d. Date signa	d (Month,	Day, Year)		
		Bocha	a Berch	nn			3713	4	6/1	5	2006		
		30. Name and address of pers Barbara	on who completed ceuse on Kircher,				r. #308	Towso	n, Md.	2120	04		
	State Registrar	31. Date filed (Month, Day, Ye		strar's Signatur	6	Soone	1						

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Florence Mary Summers 2000 JUNE 17, 1755 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 218-09-9639 Birthpleca (Stete or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Months Deys Hours 1□M 2⊠F 96 Yrs. Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 1000 Plover Court 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Raca - American Indian, Bieck, White, etc. 1 Yes 2 No If Yes, Give 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Bakers Assistant Bakery 18. Mother's Name (First, Middle, Meidan Sumema) 17. Fethar's Neme (First, Middla, Last) Charles William Ross Blanch Cremmer 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. tnforment'a Neme/Relationship (Type, Print) Ann E. Kordusky/Granddaughter 1000 Plover Court Baltimore, MD 21227 20b. Piaca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 6/19/00 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Common Dawn F. McDonald Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Finat 10 mm diseese or condition resulting in death) LESAITOTOTY Due to (or es e consequence of): Cardroe arrhythma Due to (or as e consequenca of) Due to (or es a consequenca of): 23b. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

physician s the buna

certificate has

4

After

Director

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Examiner

permit. Pages 1 and 2 should be Department of Health and Mental important: if them 27 is marked or any injury or other traumatic eve

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

lisms 23s or 28s-f show

Pygiene. other than "natural", or listna 23e of zee-vent, the Medical Examiner must be notifie

filed within 72 hours after

Saltimore, Maryland 21215-0020

Directo

Funeral

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Completed

Be

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that influsted events resulting in deeth) Last

Physician/Medical Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yee 2 No 3 Probably 4 Unknown à 24e. Wes en eutopsy performed? 24b. Were autopsy findings avellable prior to Completed completion of causa of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3月3-DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 200 No Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not ba determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 12 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, dete and pleca, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end pleca, end due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one)

P.O. Box 68760 Records, Vital 10 Division 8 To the Hospital within 24 hours a To the Funeral C

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Dey, Year) JUN 2 0 2000

CONVISON

29b. Signature and title of certi-

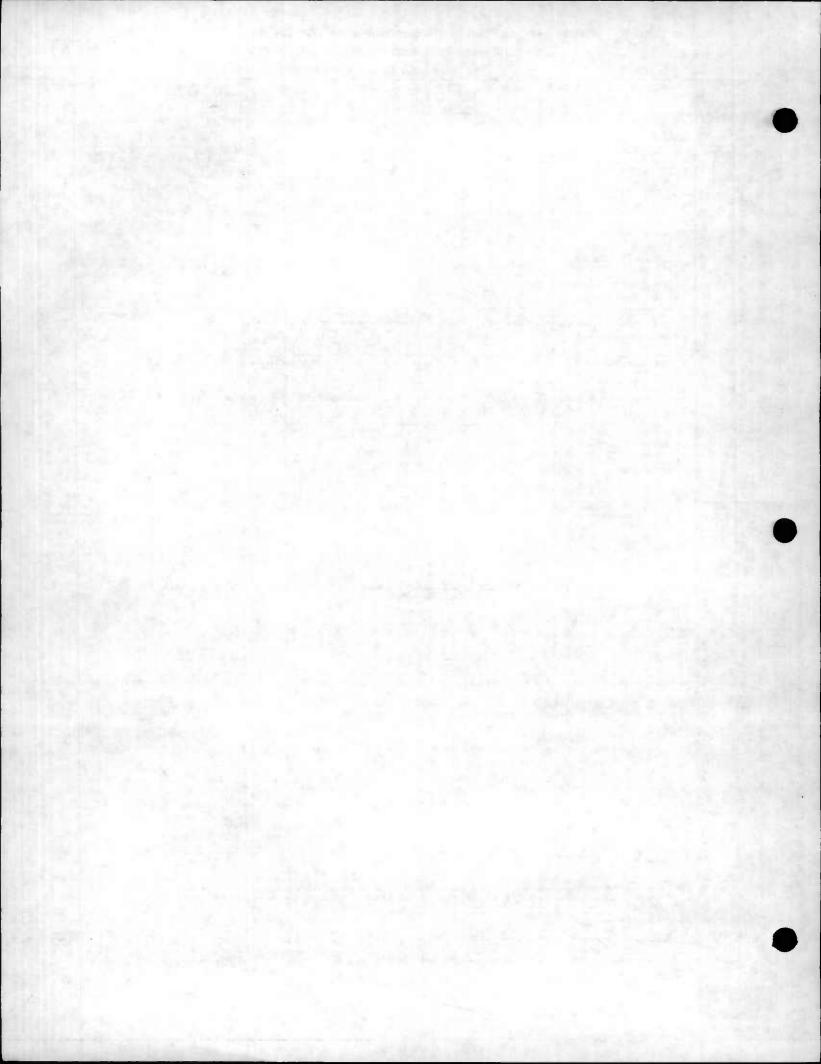
30. Name and addfe

of person who completed cause of death (ttem 23a) (Type, Print) ST. Agnos Hospital 32. Registrar's Signetura

29c. License number

121256

29d. Dete signed (Month, Day, Year)



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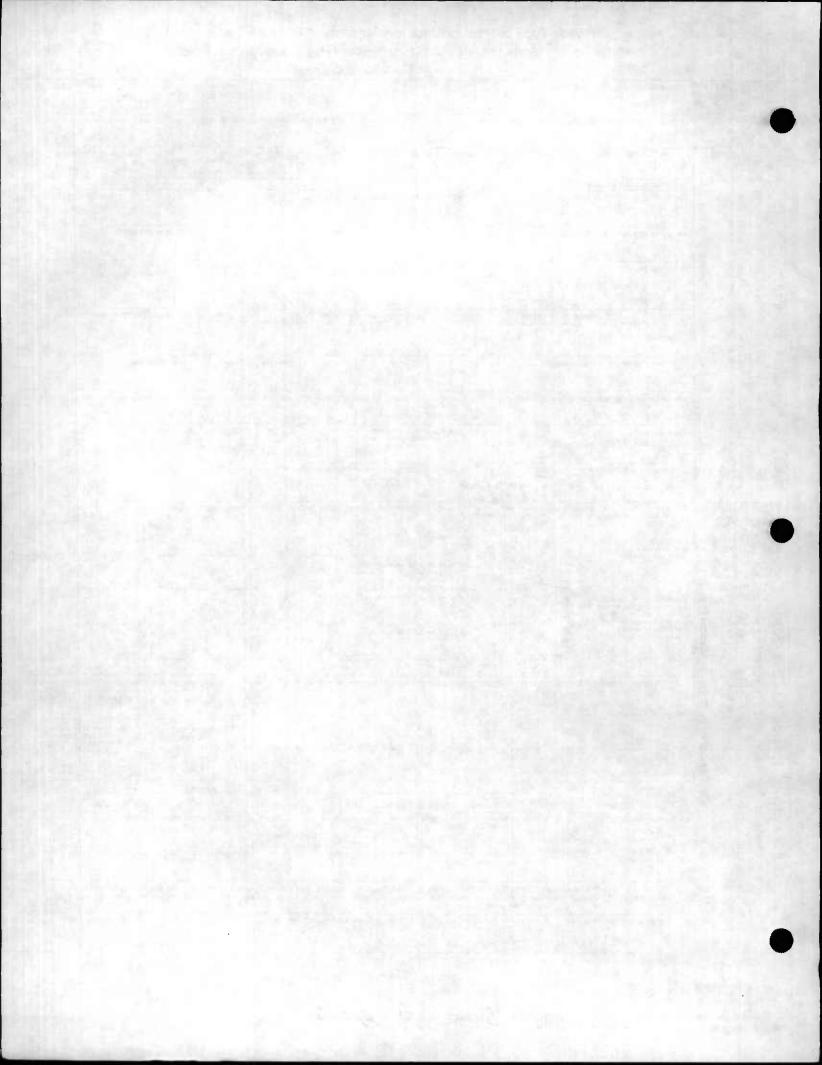
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 18, **Physician** 2000 2:04 PM Arthur L. Shepherd /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Catonsville Eldercare Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day, Year) AUG 25, 1919 9. Birthplece (State or Foreign Country)
New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 F Yrs. 122-12-9418 80 New Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. Stete 10b. County 10c. City. Town or Location Show r than "natural", or items 23s or 28s-f show 1 ☐ Yes 2X No Director Maryland Catonsville Baltimore 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code with 333 Harlem Lane 21228 USA Funeral death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status filed within 72 hours after 1 Yes 2 No UNK. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: White Specify: þ 3 ◯ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) UNK. College (1-4or 5+) Clerical Accounting i. Pages 1 and 2 should be filed w timent of Health and Mental Hygie tant: If Itam 27 is marked other ti jury or other trsumatic event, to Maryland 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Arthur Shepherd Pearl Tibbetts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 333 Harlem Lane Catonsville, MD 21228 Dawn Kalthof/Friend Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of Important: If It any Injury or once. 1 ☐ Buriel 2 XCremetion 3 ☐ Removal from State Metro Crematory, Inc. 6/19/00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Fecility Gregorchik Cremation Society of MD 299 Frederick Road Bal Edward Baltimore, MD 21228 A. 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heer failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical PNEUMONIA Examiner Due to (or as a consequence of): Examine EMPHYSEMA The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): pue physician s the buna Box 68760 Physician/Medical Due to (or as a consequence of): USB BS for P.O. Pert It. Other afgniftcant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown signed by DEMENTIA Records, þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to page 2 should Completed peen completion of ceuse of deeth? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate of Vital or Attending Physician: funeral director, 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 XNatural 5 Pending investigation after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C completely filled Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier delevel MD D26748 June 19, 2000 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Anil Uberoi, 4419 Falls Road Baltimore, MD 21211 M.D. 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 0 2000 **DHMH 16 Rev 6/95** 

**ORIGINAL** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9479 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Vera Lorraine Sudbrook JUNE 16:52 15,2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner N/A St. Agnes Hospital Baltimore 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplece (Stete or Country) | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | Tourn | T 5. Social Security Number Birthplece (State or Foreign Country) 10 M X0 F 214-20-6827 **Usual Residence of Decedent** 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 820 S. Caton Ave., Apt. 6-I 21229 USA Funera 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes X No Specify: specity: White 3 ☐ Widowed 4 ※ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Key Punch Operator Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Charles Sudbrook Ida Tayler 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Ethel Bohn/Friend 1008 Circle Drive Arbutus, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Metro Crematory, Inc. 6/19/00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 2Cremation Fostociety of Maryland, Inc. Gregorchik Edward A: 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death Immediete Cause (Final disease or condition resulting in death) SEPTIC SHOCK ACTE RENAL FAILURE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): FAI CORD RESPIRATORY Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably MUnknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 2 No Yes 2 No 25. Wes case referred to medicat examiner? 8 26. Place of Deeth (Check only one) 1 Yes ≥ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Inputient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manper of Death 28c. Injury et Work? 28b. Time of 1 Netural 2 Aceident 5 Pending investigation 1 Yes 2 No 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

BROOK Division **Funeral** 

**Director** 

ehow.

"natural", or hams 23s or 28s-f shoulded in the notified at

pomit. Pages 1 and 2 should be flied within 72 hours after togethment of health and Mental hygiene. Important: If item 27 is marked other than "natural", or he any injury or other transfe event, its Medic I samme

Physician

/Medical

Examiner

attending physician and for use as the burial-transit

been signed by the a ahould be detached

this certificate

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

Baitimore, Maryland 21215-0020

the Maryland

To the Hospital or Attanding Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Registrar DHMH 16 Rev 6/95

DR. THOMAS J. ENELOW STAGNES HEALTHCARE 900 CATONAVE BALTO, MO 21279 32. Registrar's Signature

Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year) JUNE 16, 2000

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

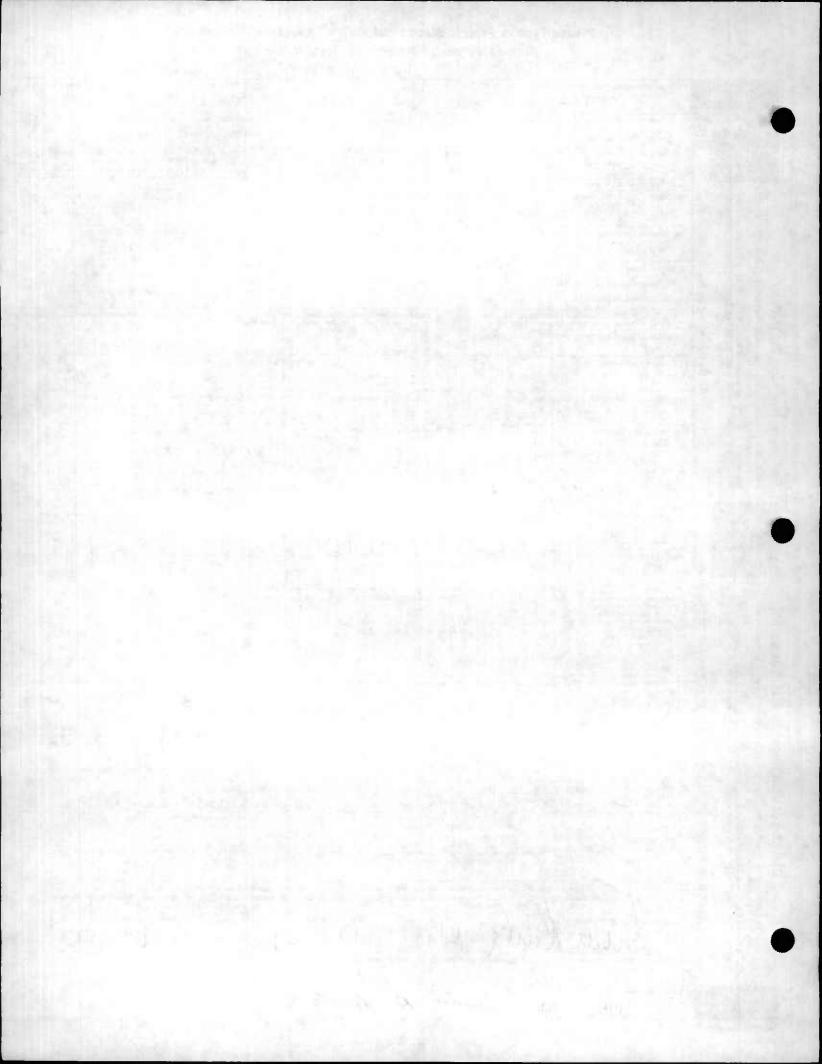
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### Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death JUNE 15, 2000 **Physician** FRIEDA SCHARE 8:25 PM /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 623 GIST ROAD WESTMINSTER CARROLL If Undar 24 Hrs. If Under 1 Year 5. Social Security Number Birthplaca (Stata or Foraign Country) 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Months Devs Hours 1□M 250 F 065-38-0959 Yrs. Director 97 DEC.16,1902 CZECHOSLOVAKIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD CARROLL WESTMINSTER or 28a-1 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 623 GIST ROAD 21157 23a U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Rece - Americen Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? 11. Marital Status Pages 1 and 2 should be filed within 72 hours steen name of Health and Mertal Hygiene, writ if hem 37 is merked other than "natural", or the ury or other trassreatic event, the Medical Experies Yes 2 No f Yas, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. ğ Specify: WHITE 3X Widowed 4 □ Divorced Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be **JOSHUA** KRANZER SHEVA LAUB 2 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 623 GIST ROAD - WESTMINSTER, MD 21157 NAOMI BENZIL / DAUGHTER 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Department of 1X Burial 2 Cremation 3 X Removal from Stata NEW MONTEFIORE CEMETERY 6/18/00 4 Donation 5 Other (Specify) PINELAWN, NY 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 at caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, an each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): The law requires that the death certificate be asscuted Sequentially list conditions, it any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of) Box 68760, Physician/Medical the Due to (or as a consequence of) for use as P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed by of Vital Records, 2 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to complation of causa of death? page 2 After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1□ Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Menney of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Neturel Division 5 Pending Investigation 1 Tyes 2 □ No death. 2 Accident after death the 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicida 28e. Pleca of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 2 4 T Homicide filled in To the Hospital within 24 hours of 29a. Certitier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner stated. completely one) 29b. Signaty dand title of cartifian 29c. Licensa number 29d. Date signed (Month, Day, Year) ho complated causa of daath (Item 23a) (Type, Print) 5 OwnsMills MD2111 rossroads i GWO KYDter 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State socks JUN 2 0 2000 Registrar

DHMH 16 Rev 6/95



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						(	Certific	ate of	Death		Reg. No.		12901					
J	Physicia		Decedent's Name (First, Middle DIANA	1 8	SANDE	ERS		2. Dete of Dee Month JUNE		O'O'ar	3. Time of Death 3:55PM							
	/Medic Examin	_	4a Facility Name (If not institution	, give street and no	um <i>ber)</i>							ol Death						
	Funeral Director		JEWISH CONVALES( 5. Sociel Security Number 212-34-9523	CENT & NU 6. Sex 1 M XOF	7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hr						h	TIMON 9. Birthp RUSS.	place (Stete or Foreign					
	P .		Usual Residence of Decedent															
	Marylar a-f ahow	tor	MD 10b. County N/A			LTIM	or Location ORE					1	0d. Insida City Limits 1 A Yes 2 No					
	death with the Maryland ms 23s or 28s-f show ms 12s or 28s-f show	i Dire	10e. Street and Number 3810 FALLSTAFF I	Street and Number 10f. Zip Code 10g. Citizan of What Coulomb 10 FALLSTAFF ROAD APT 2 B 21215 USA									ntry?					
020	within 72 hours after death ene. then "neturel", or heme 2 re-Medical Exercises ma	by Funeral Director	11. Merital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed F led 1 Yes If Yes, G	Armed Forces? If Y			ecedent of specify Cul s 2 XNo	Hispanic Orlgin? (5 ban, Mexican, Puel o Specify:	Specify Yes or No- to Rican, atc.)	Blac	e - Americ ik, Whita, WHIT!						
2-0	72 ho	eted	15. Deceden (Specify only higher	's Education	)	16a. [	Decedent's U	Jsual Occu	pation duning most of we	orkina	16b. Kind of Bu	ısiness/în	dustry					
21215-0020	withir than	Completed	Elementary/Secondary (0-12)	T	(1-4or 5+)		iiie. DO NO EMAKEI		during most of wo		OWN HO	ME						
ng	be filed tal Hygi d other event, t	e e	17. Father's Name (First, Middle,	Last)	A				The state of the s	ma (First, Middle,		e)						
<u>X</u>	Men	2	JACOB	1.07/4	CHARNEY				DVORAH		NTOR							
, Maryland	and 2 sho selth and n 27 la m er traum		19a. Informant's Name/Relations JACOB SANDERS/S			19b. 271	Mailing Add	rass (Stree COUR	T ROAD BA	LTIMORE,	or, City or Town, MD. 21	State, Zip 209	(Code)					
altimore,	permit. Pages 1 to Department of He Important: If Item any Injury or other page.		20a. Method of Disposition  1 M Buriel 2 Cremation 3 Removel from Stata 4 Donation 5 Other (Specify)  20b. Place of Disposition (Neme of cemetary, crematory of other place)  AGUDATH ISRAEL CONGREGAT— TON								20c. Location - City or Town, State  O ROSEDALE, MD.							
)	Physician /Medical Examiner	Sr.	23a. Part1. Enter tha disease, or shock, or haart failura. List Immediate Causa (Final disease or condition resulting in death)	complications that only ona cause on a	each line.	Sex or as a co	psequance	of):				1	Approximate Interval Batween Onsat and Daath					
0X 68/60,	hysicie the bur	Medicai	Medicai	Medica	Medical	Sequentially list conditions, if any, laading to immediate cause. Enfer Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	6. Non		or as a co	ensequence	oi).	an deyen	erative	distri	ar.	years		
ão Ros	d for u	ciar	Part II. Other algnificant condition	ne contribution to	doath but not re	eulting in	the underhie	22 621160 6	iven in Part I	23h Did	tohacco use co	ntribute t	o the cause of death?					
5.	es that the death certific igned by the attending p be detached for use as	, Physician	Tatil. Street eiginicant conduct	wa contributing to	Joann Dut Hot 18	summy m	une underlyn	ig cause g	ivali ili i giti.		Yes 28 No		bably 4 Unknown					
Hecords,	requir seen s hould	Completed by			Υ.					24a. Was perfo	an autopsy rmed?	av	fere autopsy findings vailable prior to ompletion of cause death?					
USION OF VICAL IN trending Physician: The death. ctor: After this certificata h y the funeral director, page	The ata h	50									res 2 No	1	☐ Yes 2☐ No					
	entific ector,	Be l	25. Was casa rafarred to medica examiner?		26. Place of Death (Check only one)													
		2	1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)									(y)					
	ath. x: After the funera	Certification:	27. Manner of Death  1 Drivatural 5 Pendin  2 Accident invasti	pation	of Injury oth, Dey Year)	28b. Time of linjury Work M 1 1 Y			ury at ork? □ Yes 2 □ No	28d. Describe how Injury occurred		red						
	s after de N Directe ed in by t	Certific	3 ☐ Suicide 6 ☐ Could datarm	ined Zoa. Flac	e of Injury - At I ding, atc. (Spec	n, straaf, fac	281. Location (Street and Number or Rural Route Number, City or Town, State)											
	Hospi 24 hou Funer taly fil	edical		Examiner: On the I					tima, date and place opinion, daath occ									
	within 2 To the comple	M	29b. Signature and title of cartifie						nse number		29d. Date signed (Month, Day, Year)							
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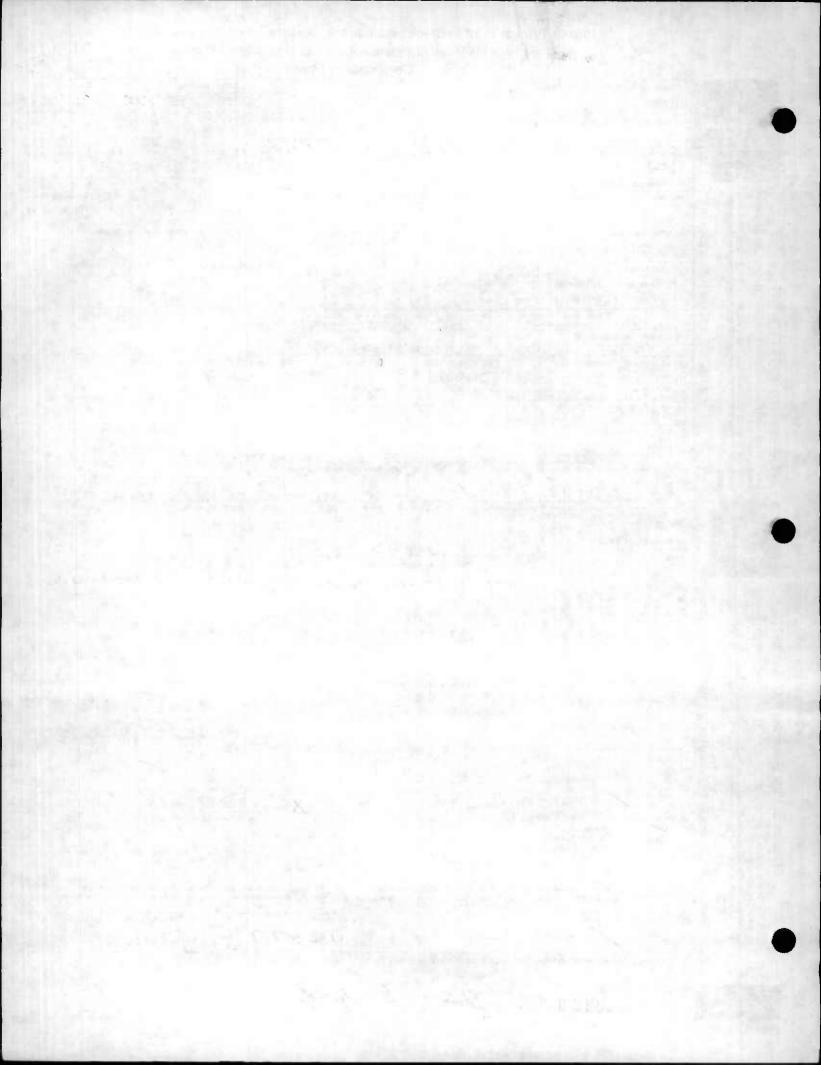
Registrar

State

Sporks

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Dey, Year)
JUN 2 0 2000



## Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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					Cei	rtificate of	Death			Reg. No.			
		Decedent's Name (First, Middle, Last)     Detect Deeth Month Da									Vanc	3. Tima of Death	
	sician edical	Clare Francis Maryann Surdel, O.S.F.							June			11:49 a.m.	
	edicai miner	4a Facility Name (If not institution, giv	re street and number	r)			4b. City, To	wn, or Lo	ocation of Deatl				
		Good Samaritan	Hospital				В	alti	more	100	N/	Α	
Fune	ral	5. Social Security Number 6. 5	Sex . 7. A	ge (In yrs. last	birthday)	If Under 1 Year	If Under	24 Hrs.	8. Dete of Bir (Month, De	th		nplace (State or Foreign untry)	
Direct		213-42-3600	1□ M 2Å) F	58	Yrs.	Months Days	Hours	Min.	May 24	1942		Maryland	
70		Usual Residence of Decedent							HIGY_ET	, 1776		idi y I dild	
Mon M	10	10a. State 10b. County		10c. City, To	own or Lo	ocation						10d. Inside City Limits	
7 70	tor	Maryland N/	Α	Ba1	timo	re						1 XYes 2 □ No	
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ar deal	Funeral	11. Marital Status	12. Was Decedent	t Ever in U,S.	13.	Was Decedent of H	lispanic Ori	gln? (Sp	ecity Yes or No	- 14. Ra		rican Indian,	
	2	1 Never Married 2 Married	Armed Forces	No				i, Pueno	HICAN, etc.)		ck, White	etc.	
2 5 MM	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:			1□Yes 2X No	Specify:			Speci	y: W	hite	
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and N	-	19a. fnforment's Name/Relationship (		igious 1	19b. Meili	ng Address (Street	and Numbe					ip Code)	
nd 2 alth a 27 la		Sr. Doris Johnson.			Sister	s of St. Fr	rancis	609	S. Conve	ct Rd A	ston	PA 19014	
	1	20a. Method of Disposition		20b. Place	e of Dispo	osition (Name of		005	Date	20c. Location			
A PER P		1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		9		matory or other place			/20 /00	Daltim	220	Manuland	
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	STI C	Miore.C	ing.			LEONARD	J. RU	CK,	INC.	Baltimo	re,	MD 21214	
	- 33	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line.  Approximate Interval Between											
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Division of Vital To the Hospital or Attending Physicien: Tentin 24 hours after death. To the Funeral Director: After this certificat completely filled in by the funeral director, p.	on	27. Manner of Death 1 XNetural 5 ☐ Pending	28a. Dete of Inj (Month, De	ay Year)	b. Time or Injury	Wo			28d. Describe	how injury occu	rred		
Series of the fath	cat	2 Accident investigation 3 Suicide 6 Could not b					Yes 2	No					
Ar Ar Ar Ar Ar Ar Ar Ar Ar Ar Ar Ar Ar A	Certification:	4 ☐ Homicide determined	286. Piece of it	njury - At home rtc. (Specify)	, farm, str	reet, factory, office			City or To		ber or Hu	iral Route Number,	
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losp t hou une	edicai	29e. Certifier 1 Certifying Ph	yefcian: To the best	t of my knowled	dge, death	h occurred at the time	ne, date an	nd place,	and due to the	cause(s) and n	enner as	stated.	
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0 T 2 0	Σ	29b. Signature and title of cartifier		•		29c. Licens				29d. Date sign			
11		and	No 10	m	us)	D10	0091			June	19,	2000	
IV	10	30. Name and address of person who	completed cause of	deeth (Item 23	a) (Type,	Print)					7	WE PET IN	
1	0	Arthur A. Serpi				er Drive	Tows	on, I	Marylan	d 2120	4		
	State	31. Dete filed (Month, Dey, Year)				mels							
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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 19483 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** STECYK STEFAN 2000 Sune /Medical 4b, City, Town, or Location of Death 4c. County of Death Excility Name (If not institution, give street and number) Examiner morelit 5. Social Security Number N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs/ Mat birthday) 8. Dete of Bigth (Month, Day, Year) Birthpiece (State or Foreign Country) **Funeral** Deys Months Houra Min. 100 M 2□ F 216-30-9011 79 Director July 20, 1920 UKRAINE Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d Inside City Limits 1XXYes 2 No Director 280-1 MD. N/A BALTIMORE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 932 S. KENWOOD AVENUE 21224 UKRAINE Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene. Int! If Item 27 is marked other than "natural", or the 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Saitimore, Maryland 21215-0020 Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5 MACHINE OPERATOR LUMBER CO 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be **PYTACHUK** STEFAN STECYK ANNA 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 407 S. ANN STREET, BALTIMORE, MARYLAND 21231 ANNA M. STECYK/ DAUGHTER 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If Its any Injury or o 1)XXBurial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) MICHAEL'S UKRAINIAN 6/21/00 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility
LILLY & ZEILER INC. FUNERAL HOME
1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onget and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical CONGESTIVE HEART FAILURE 6 months Examiner Due to (or es a consequença of) Physician/Medical Examiner AORTIC STENOSIS 1 year The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest use es the burial-tran Due to (or es a consequence of). Box 68760. Due to (or es a consequenca of) P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PROSTATE CANCER Records, þ 24b. Were sutopsy findings evailable prior to completion of cause of deeth? 24e. Wes an eutopsy periormed? Be Completed page 2 2 No 1 ☐ Yes 2 No 1 ☐ Yes of Vital Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Medical Certification: To After this 27. Menger of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury et Work? Division or Attending 1 Neturel 2 Accident 5 Pending investigation after death. 1 Yea 2 No the 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 29a Certifier To the best of my knowledge, deeth occurred et the time, date end placa, end due to the ceuse(s) and menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) and manner stated.

**DHMH 16 Rev 6/95** 

State Registrar

KELLY DOOLEY, 31. Dete filed (Month, Day, Year) JUN 2 0 2000

29b. Signature and title

600 N. WOLFE 32. Registrer's Signature

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

ST , TOWER 110, BALTIMORE, MARYLAND 21287

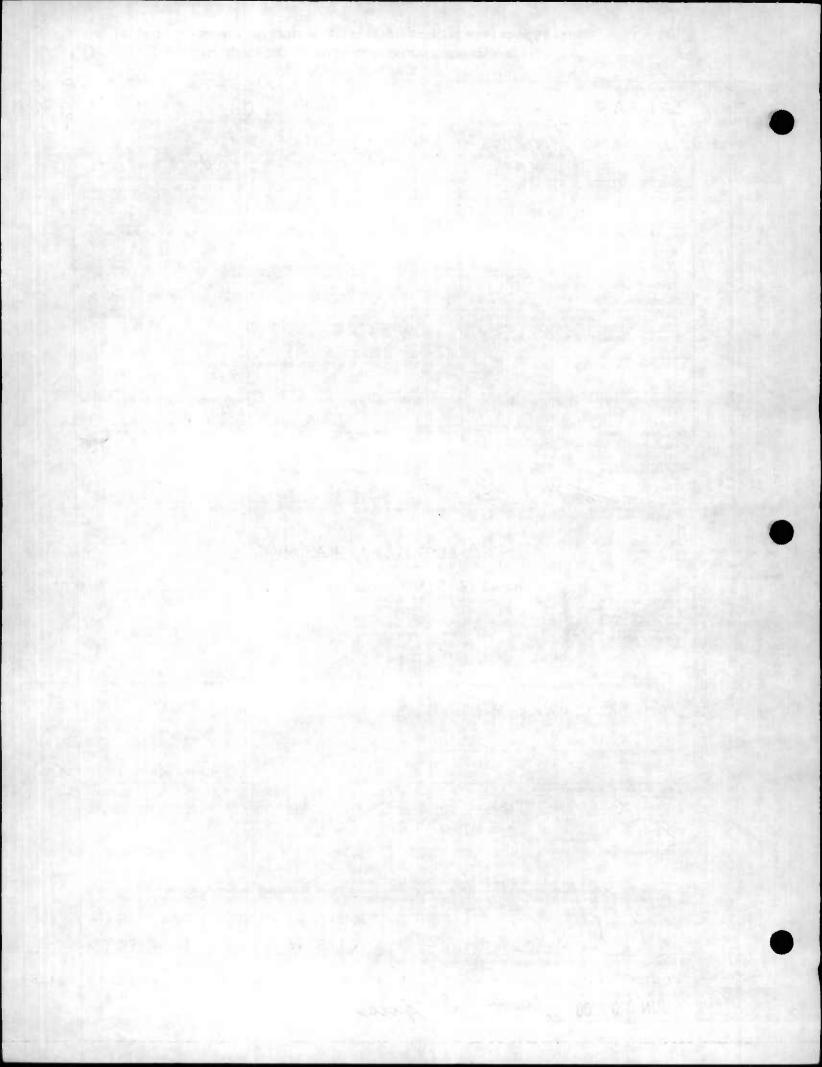
an

29c. License number

RESOOO

29d. Dete signed (Month, Day, Year)

JUNE 18, 2000



## Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 9,2000 JULIA M. SCHOFIELD une /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner LEVINDALE GERIATRIC CENTER & HOSPITAL BALTIMORE n/a If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1□M 2⊠F Months 215147870 Director 78 JUNE 9 1922 MARYLAND Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f short the Medical Examiner must be notified at NEWYes 2 No Director BALTIMORE n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 USA 1045 RODMAN WAY Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Who If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, 11. Meritel Status Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ XNo Specify: WHITE Specify: à Year or Detes: 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) OWN HOME 6 0 HOMEMAKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be next of Health and Mental int it itsm 27 is marked o DAVE REMMINGTON MARY FINNEGAN 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Important: If Itsm 27 any Injury or other tr SAMUEL A. SCHOFIELD / HUSBAND 1045 RODMAN WAY BALTIMORE, MD 21205 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 X Buriat 2 ☐ Cremetion 3 ☐ Removel from State HOLLY HILL 6/23/00 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lies 22. Name end Address of Fecility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTIMORE, MD 21237 23a. Perff. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Fine) disease or condition resulting in deeth) Examiner Examine Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Emphysema Physician/Medicai Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveitable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 Yes 25. Wes cese referred to medice examiner? Be 26. Place of Deeth (Check only one) Hospitet: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 養 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Division 1 Neturet 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide after To the Hospital Wilhin 24 hours after To the Funeral Dir 8 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner as stated 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end menner stated. edical 29a, Certifior 29c. License number 29d. Date signed (Month, Day, Year) person who completed ceuse of deeth (Item 23a) (Typa, Print) 23 43 hemer no 32. Registrer's Signature 31 Dete filed (Month, Day, Yea State

**DHMH 16 Rev 6/95** 

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 7-15-2000 amend item 10b per infrmt. State of Maryland / Department of Health and Mental Hygiene
AMD#1,4B-C,10A,10C,f&19B,20C PER MD.& INFMNI G785 JAB Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death HELENE MAHON SCARLATA **Physician** Month 00 12,00 DOON /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANVAPOLIS; 4c. County of Death Examiner tarbor Ausing enter If Under 1 Year ANNE ARINDEL 90 If Under 2 24 Hrs. 7. Age (In yrs. last birthday) 9 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 209-18-0118 10 M 20F Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits. PA. SCRANION Lackawana 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with Department of Health and Mental Hygians.

Department of Health and Mental Hygians.

Sany Injury or other treumatic award, the Mental Examiner meast he ready injury or other treumatic award, the Mental Resource treatment. 18508 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 21215-0020 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry Board of Education Elementary/Secondary (0-12) College (1-4or 5+) Baitlmore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry. outh erine HItchings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PC 21090 Kd. Se-Vaughter 20b. Place of Disposition (Name o 20c. Location - City or Town, State 1 DBurial 2 CiGu SCRANTON PA 4 Dortilion 5 De ther (Specify) 2000 Ca sature of Fun Name and Address of Facility elipolitax Chapel P.C. Broadway Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Š Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 2 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physical Within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 S Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ranakull ms. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N Javakuli Printe Cerys Hosp cheverly MD 20785 Plinte George

DHMH 16 Rev 6/95

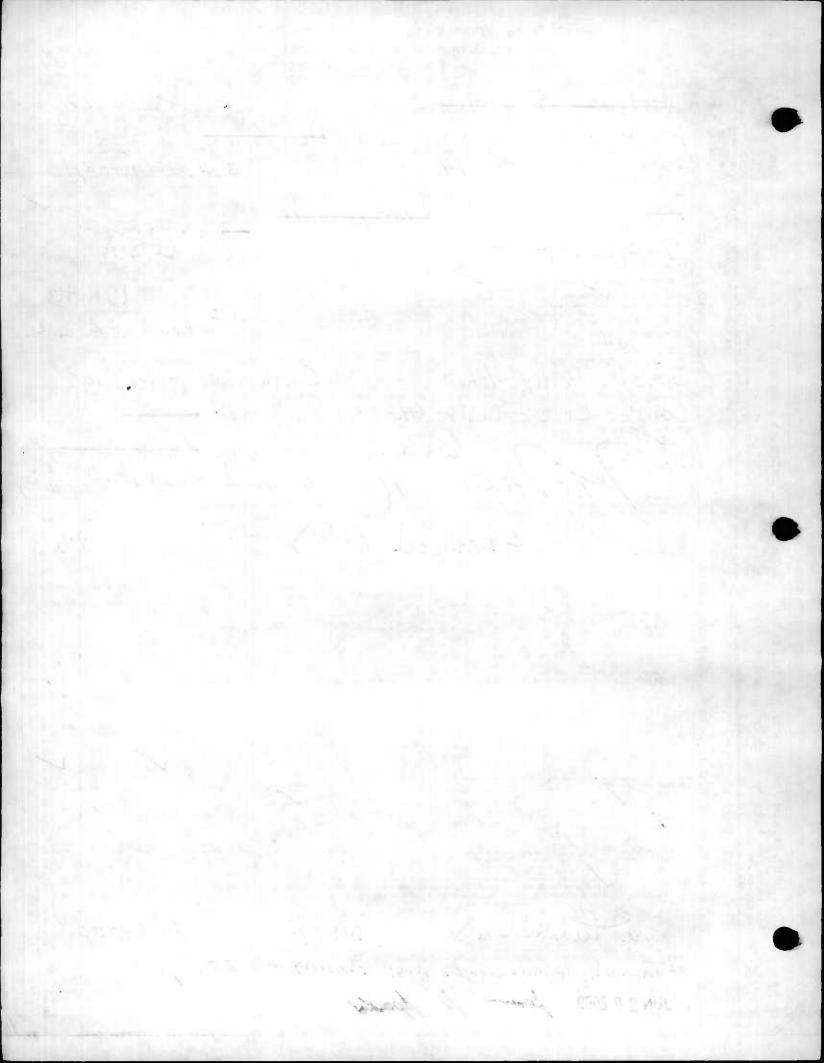
State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 0 2000

32. Registrar's Signature



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Talbert 11:57 Kerry 16 2000 une /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Hopkins Hospital he Johns If Under 24 Hrs. 6. Sex 1/SM 2□ F If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. Jast birthdey) 8. Date of Birth (Month, Day, Year) Funeral Days 213-86-8331 Months Hours 33 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits mast be notified at 1 Yes 2 No Director MARYLAND 10e. Street and Number 10a. Citizen of What Country? FAVETTE STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 B.No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA. Funeral 14. Race - American Indian, Black, White, etc. Hema! 11. Marital Status 1 Never Married 20 Married 8 1 Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11++GRADE BOB WHITE ROOFING CO of Heelth and Mental Hygie if flam 27 is marked other the ir other traumatic evant, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) PERRY VICTORIA MORRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1547 HOMESTEAD ST. BALTIHORE MD. 21218 ce of Disposition (Name of Date 20c. Location - City or Town, State (MOTHER) VICTORIA TALBERT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1. Burial 2 Cremation 3 Removal from State 5 WESTERN STAR CEMETERY6-21-00 CATONSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217 21. Signature of Funeral Service Licenses FULTON AVE., BALTO, MD. 2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** fmmediate Cause (Final disease or condition resulting in death) /Medical 12hows **Examiner** Physician/Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 1 No. 3□ Probably 4□ Unknown Be Completed by Kalemia 24b. Were autopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? Renal failure 1 No Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: 1 ⊠ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 | Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

DHMH 16 Rev 6/95

the Maryland

Pages 1 and 2 should be filed within 72 hours after

The law requires that the death certificate be executed

Box 68760,

P.O. I

Division of Vital Records,

21215-0020

Saltimore, Maryland

Registrar

31. Date filed (Month, Day, Year) JUN 2 0 2000

29a. Certifier

29b. Signature and title of

Jeanine Rowanelli Tower

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe Street Baltimore Mary lund

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es ststed.

| Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

16,2000

JUN 2 0 2803 James 13. Apresid

### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death JUNE 10 Day 2000 EDWARD FRANCIS TEIPE 09:51am 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 1616 Howard Ave. Essex Baltimore If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) June 12 1924 9. Birthplaca (State or Foraign Country) Maryland 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Days Months Hours 10 M 2□ F 217-12-3281 75 Yrs. Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Essex 1 Yas 2 XNo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1616 Howard Ave. 21221 USA Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Ever in U,S. Armed Forcas? 1.X Yas 2 □ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: White Specify: 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Baltimore County Truck Driver 12th 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) John A Teipe Elizabeth Desch 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander Norman / son 1600 Howard Ave. Baltimore 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 □ Donation 5 □ Othar (Specify) Metro CrematoryInc. 6/13/00 Baltimore MD. 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Connelly Funeral Home of Essex 300 Mace AVe. Baltimore Md. 21221 23a. Part1. Enter the disease, or complexitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only on cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final 15 minutes woun disaasa or condition resulting in daath) Sequentially list conditions, if any, laading to immediate causa. Entar Undarlying Causa (Diseasa or Injury that initiated evants resulting in death) Last Dua to (or as a consequance of): Due to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3□ Probably 4) Unknown 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to complation of causa of death? 1 Yas 2 No 1 Yas 2 No 25. Was casa referred to medical 26. Place of Death (Check only one) ninar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4□ Nursing Homa 5 Rasidence 6 □ Othar (Specify) Yas 2□ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Selfinflicted Gun Shot wound 1 Natural 5 Pending June 10,2000 09 36 AM 10 28e. Place of Injury - At homa, farm, street, factory, office building, etc, (Specify)

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

ral', or items 23s or 28s-f shore Examiner must be notified at

72 hours after

filed within 7 I Hygiene. other than "n

permit. Peges 1 end 2 should be file Department of Health and Mentel Hy Important: If flem 27 is marked othe any Injury or other traumatic event, parce.

Baitimore, Maryland 21215-0020

Director

Funeral

by

Completed

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Physician/Medical Be Certification: To

certificate be executed stending p signed be de by Completed page 2 certificate Attending Physician: this death.

Records,

Division of Vital after death Director: b 24 hours aft Funeral Di letely filled in edicai To the H within 24 To the Fi

State Registrar

Militello 31. Date filed (Month, Day, Year)

Investigation

6 Could not be detarmined

2 Accident

3 Suicida

29a. Cartifier

4 ☐ Homicida

(Check only one)

29b. Signatura and titla of certifier

Deputy

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print)

29c. Licansa number 18667

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and mannar as stated.

200 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yas 2 No

29d. Data signed (Month, Day, Year) June 12,2000

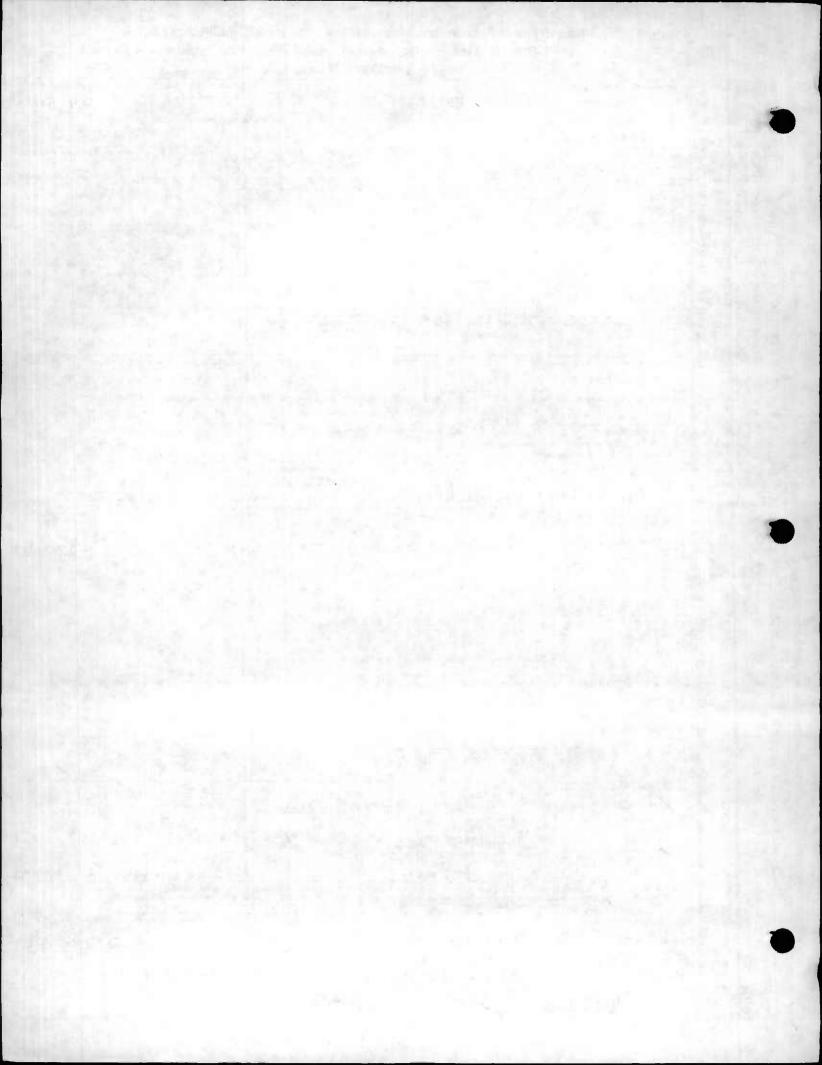
281. Location (Street and Number or Rural Routa Number, City or Town, State)

16/6 Howard Ave Essex Md 21221

Greene ST. Baltimore, M.D. 21201

22 M.D. 32. Registrar's Signatura

Home



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 19488 State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MSan 12:15 AM JUNE 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M XXF 69 215-30-3302 Dec. 11,1930 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Baltimore 10e Street and Number 10f Zio Code 10g. Citizen of What Country? 1219 Stella Drive 21207 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 1 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leo B. Kelly Mary Bavis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Tacka/Daughter 9463 Fens Hollow, Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 6/23/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00741 Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 Lenemeer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Thpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

the death certificate be executed Box 68760. P.O. Records, of Vital

physician s for use The law requires thet 2 page 2 s Physician: this funeral After or Attending Division n 24 hours after deetn.

n 24 hours after deetn.

he Funerel Director: After To the Hospital o within 24 hours aff To the Funerel Di completaly filled in

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

Show r 28a-f show

r than "naturel", or items 23a or

pemit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or ite any injury or other treumetic event, the Medical Examina

Physician /Medical

Examiner

ician end buriel-transit

Examiner

Physician/Medical

Completed by

Be

Certification: To

edical

Baitimore, Maryland 21215-0020

with the Maryland

death

State Registrar

31. Date filed (Month, Day, Year) JUN2 0

29b. Signature and title of certifier

4 Homicide

29a. Certifier (Check only

> 32. Registrar's Signature 2000

ess of person who completed cause of death

R

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

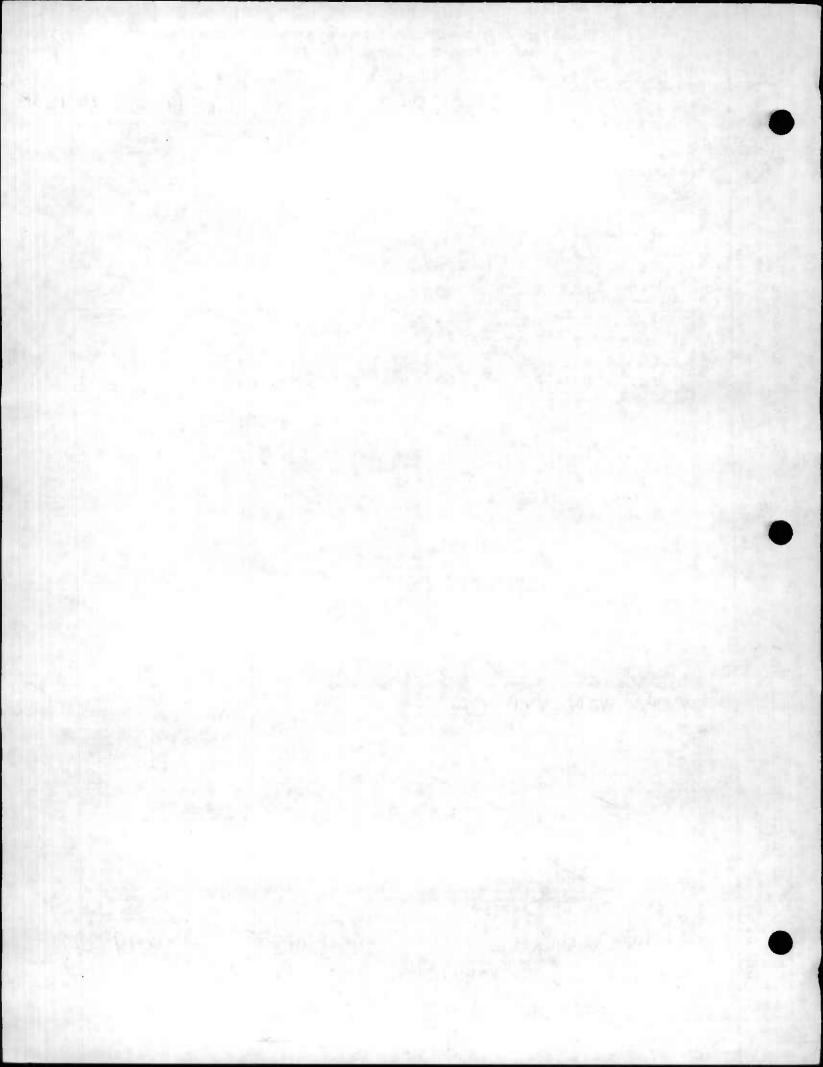
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 91,89 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Month Year **Physician** 2000 2145 Thomas Albert Thompson June 18 /Medical 4a Facility Name (It not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year 8. Date of Birth (Month, Day, Year)
Aug. 21, 1916

8. Birthplece (State or Foreign Country)
Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 24 Hrs. **Funeral** Hours Months Deys 10XM 20 F 83 Yrs Director 215-03-0359 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Pikesville Nems 23s or 25s-f the Medical Examiner must be notifi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 McHenry Avenue USA Funeral 21208 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 XYes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried ò Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 al Hygiene. Elementery/Secondary (0-12) 8th Grade College (1-4or 5+) Mechanic Frehauf Trailer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Department of Health and Mental Important: If Ibm 27 is marked or any Injury or other traumatic eve Valentine Thompson Maryanna Wrebeski 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Florence Thompson; Sister-in-Law 219 McHenry Ave; Pikesville, MD 21208 altimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Buriel 2 ☐ Cremation 3 ☐ Removel from State 6/21/00 St. Barbaras Cemetery Houtzdale, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Neme and Address of Facility Loring Byers Funeral Directors Inc. know 8728 Liberty Road; Randallstown, MD 21133 23a. Par Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ships for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Ceuse (Final nemana disease or condition resulting in death) Examiner Due to (or es a consequence of): Physician/Medical Examiner Sepsis The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Kespiraten distrus Box 68760. the Due to (or es a consequence of) Chyperkalema te Rena you signed by the attending the detached for use Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. hypertenson 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Pentre Vleen disease 24a. Was an eutopsy performed? Completed Cenemal Lascoler disease 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) end manner stated. Medicai 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) June 18, 2000 AT 2438946-P15 mo 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 201 E. University Bultonne MD 21217 Harrisin Johnson Parkreay mo 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State JUN 2 0 2000 Registrar

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Day Month Vest 8:20 P.M. JUNE 16, 2000 ALICE L. TRABAND 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PARKVILLE If Undar 24 Hrs. OAK CREST VILLAGE CARE CENTER BALTIMORE If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Days 1□M 2□F Months Hours VIRGINIA 212-10-9388 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No BALTIMORE PARKVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 8810 WALTHER BLVD. APT. 2012 21234 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: 1 ☐ Never Married 2☐ Married 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) STATOR WINDER BLACK & DECKER 11TH GRADE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) HATTIE PORTERFIELD FREDERICK STIFF 19a, Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 WALTHER BLVD. APT. 2012 PARKVILLE, MD 21234 JOSEPH P. TRABAND HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 6/19/2000 MORELAND MEM. PARK HILLENDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility THE JOHNSON FUNERAL HOME, P.A. N Enter the disease, or complications that caused the death. Do not enter the next, or heart failure. List only one cause on each line. Approximate Approximate Interval Between Onset and Death LOCH RAVEN BLVD. TOWSON, MD Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of death?

**Physician** /Medical Examiner

Department of Health a important: If frem 27 is any injury or other tra-

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

Show

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Hygiene.

Mental

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Division 6 To the Hospital within 24 hours a To the Funeral C

Medical completely

State Registrar

Physician/Medical Completed by Certification: To Be

Examiner

JUN 2 0 2000

5 Pending investigation

6 Could not be determined

25. Was case referred to medicel examiner?

1 Yas 2 No

27. Manner of Death

Natural

3 ☐ Suicide

29e. Certifier

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

Hospital:

28a. Dete of Injury (Month, Day Year)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes

28d. Describe how injury occurred

Other: Nursing Home 5 Residence 6 Other (Specify)

26. Plece of Deeth (Check only one)

2 1 No

1 ☐ Yas 2 ☐ No

Blup Parkville, Md 21234.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Jume and address of person who completed cause of death (Item 23a) (Type, Print)

880 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

**DHMH 16 Rev 6/95** 

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

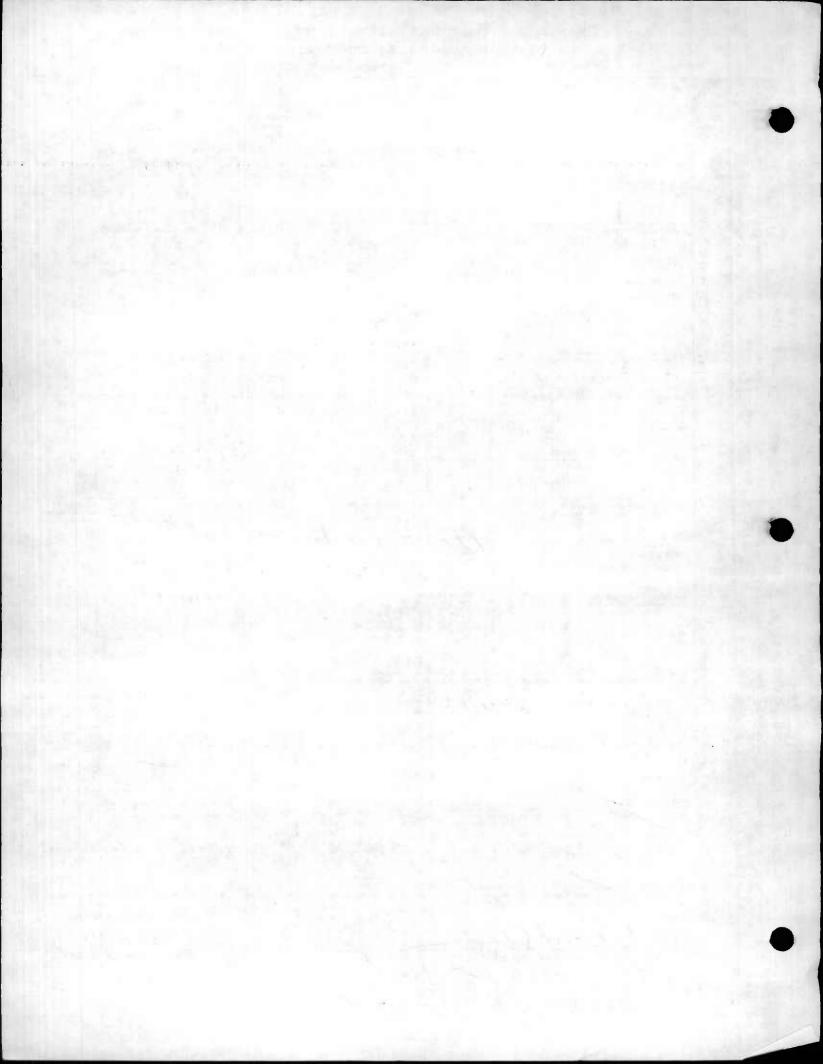
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene | 9 4 9 |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 19492 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedeni's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Day **Physician** Marian M. Vinceller June 12:15 PM 17, 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Keswick Nursing Home Baltimore N/A 7. Aga (In yrs. last birthday)
93 Yrs.

If Undar 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year)
SEPT 16, 1906 5. Social Security Number 269-40-5365 6 Sax Birthplaca (State or Foreign Country) **Funeral** 10 M XD F Director Usual Residenca of Decedent death with the Manylend 10a. State 10b. County r than "naturel", or items 23s or 28s-f show the Medical Experient must be nultied at 10c. City, Town or Location 10d. Inside City Limits 1 No 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 W. 49th Street 21211 USA Funeral 12. Was Decedani Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes/ Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes X No Specify: White þ Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked oth any linjury or other traumatic event once. 17. Falhar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Bard Minnie Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne V. Jackson/daughter 403 Wingate Rd., Baltimore, MD 21210 20b. Piace of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 6/19/00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Aicansee 22. Name and Addrass of Facility 23a. Part1. Enlar the disease, or complications that caused the death. Do not anier the mode of dying, such as cardiac or respiratory arrest,

Approximate of the disease, or complications that caused the death. Do not anier the mode of dying, such as cardiac or respiratory arrest,

Approximate of the disease, or complications that caused the death. Do not anier the mode of dying, such as cardiac or respiratory arrest,

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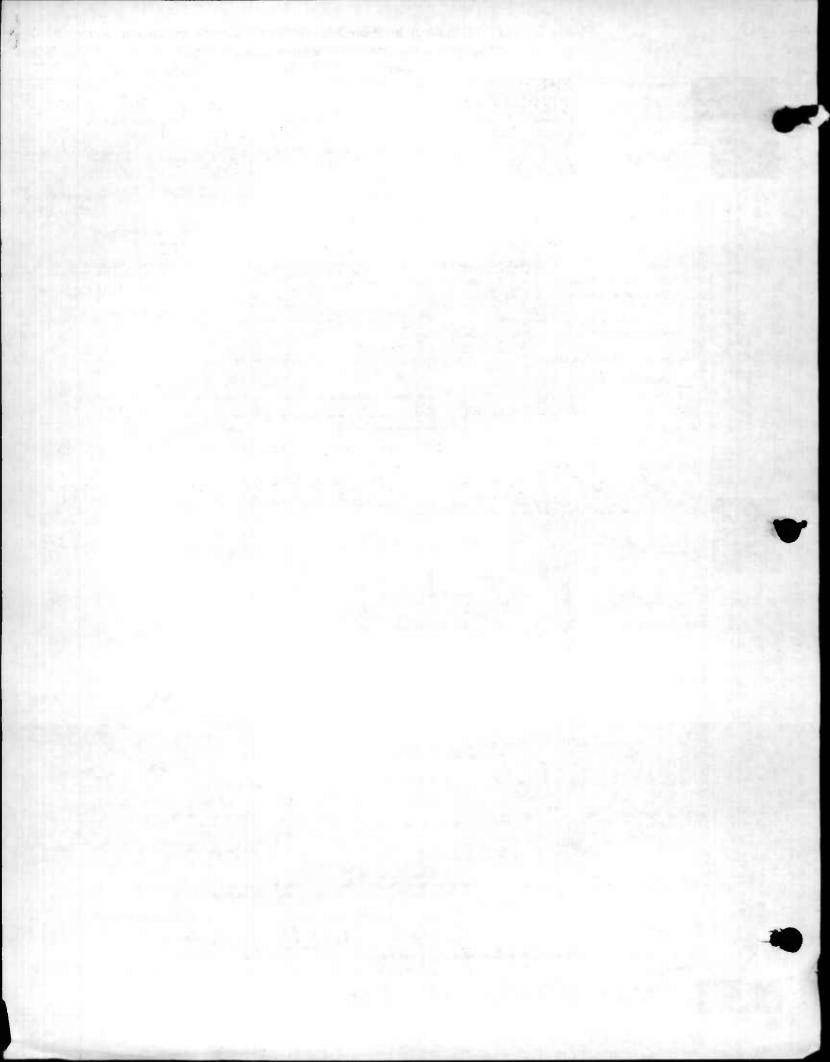
Onset and Death **Physician** Immediete Cause (Final diseasa or condition resulting in death) advanced dementra, unspecifica /Medical 10 years **Examiner** Due to (or as a consequence of): The law requires that the death certificete be executed ettending physician end for use as the buriel-trensi Physician/Medical Exam Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Box 68760 that Initiated events resulting in death) Last Due to (or as a consequence of) this certificate has been signed by the elel director, page 2 should be detached Division of Vital Records, P.O. Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certification by the funeral director. Be 25. Was case referred to amedica 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 1 Yas 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accidant 3 Suicide 6 ☐ Could not be 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicida edicai 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the ceuse(s) end menner as stated.

2 Madical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil 29e. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M Teabelle mare grege 17) June 19, 2000 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

TI DOMBELLE MACGREGOR, KESWICK, 700W-40% STREET, BALTIMORE, MARYLAND 21211

32. Registrar's Signeture

State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death JUNE **Physician** /Medical Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner TOW HABOR 7. Aga (In yrs. last birthday) II Uni BALT, MORE If Undar 24 Hrs. 8. Date ANION If Undar 1 Year Months Deys 5. Social Security Number 6. Sax 8. Dala of Birth 9. Birthplaca (Stata or Foraign Funeral Deys Hours 1□M 20 F 212-09-0013 Director Usual Rasidance of Decedant with the Maryland 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits show 1 Yas 2□ No Funeral Director BALTIMORE 288-1 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 23a or 21224 U.S.A INWOOD Hems 12. Was Decedant Evar In U.S. Armed Forces? 1 Yas 2 No If Yas, Give Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. be filed within 72 hours after 1 Navar Married 2 Married 5 1□ Yes 2 No Specify. Be Completed by 3 Widowed 4 □ Divorced Yaar or Datas: "naturef" 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry al Hygiene. Elamentary/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER Baltimore, Maryland 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middle, Last) Department of Haalth and Mental important: If them 27 is merked or any injury or other traumatic eve Pagas 1 and 2 should 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Aural Routa Numbar, City or Town, Steta, Zip Code) 2/146 Point SEVERNA, PARK, MD 20c. Location - City or Town, State 20b. Placa of Disposition (Nama of cematary, cramatory or other) 20a. Mathod of Disposition 1 Buriel 2 Cramation 3 R Donetion 5 Other (Specify) Data UNE 23 3 Ramoval from State 21. Signatu 22. Nama and Addrass of Facility of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failute. List only one cause on each line. Approximata Intarval Between Onset and Daath **Physician** Immediata Causa (Final disaasa or condition rasulting In death) INFARCTION /Medical ACUITE MYOCARDIAL **Examiner** Dua to (or as a consequanca of) Physician/Medical Examiner DECLUSION ANTERY ACYTE CORONARY The law requires that the death cartificate be axecuted Sequentially list conditions, if any, laeding to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last ANTENIOSCLEROSIS ONONARY Dua to (or as a consequanca of) P.O. Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown INSUFFICIENCY RENAL Division of Vital Records, þ within 24 hours aftar death. To the Funeral Director: After this cartificata has been siy completaly filled in by the funeral director, page 2 should I 24b. Ware autopsy findings available prior to complation of ceusa of daath? Be Completed 24a. Was an autopsy performad? 2 0 No 1 ☐ Yas 2 ☐ No 1 Yas or Attending Physician: 25. Wes casa refarred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 20 No Medical Certification: To 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA Mennar of Death 28c. Injury at Work? 28a. Dete of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how Injury occurred Natural 2 Accidant 5 Panding 1 Yes 2 No invastigetion 6 Could not be datamined 281. Location (Straat and Number or Rural Route Number, City or Town, Stete) 3 Sulcida Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29e. Cartifier (Check only one) Certifying Physician: To tha best of my knowladga, death occurred et the time, dete and placa, and dua to the causa(s) end menner es stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and placa, and dua to the cause(s) and manner stated. 290. 5 29c. Licansa number 29d. Date signed (Month, Day, Year) 20 - 2000 hD.

DHMH 16 Rev 6/95

Registrar

301

ST. PAUL PLACE - BALTIMONE MD 21202

30. Naire and addrass of person who complated causa of death (Itam 23a) (Type, Print)

32. Registrar's Signatura

JOSEPH D. NOTARANGELO M.D.

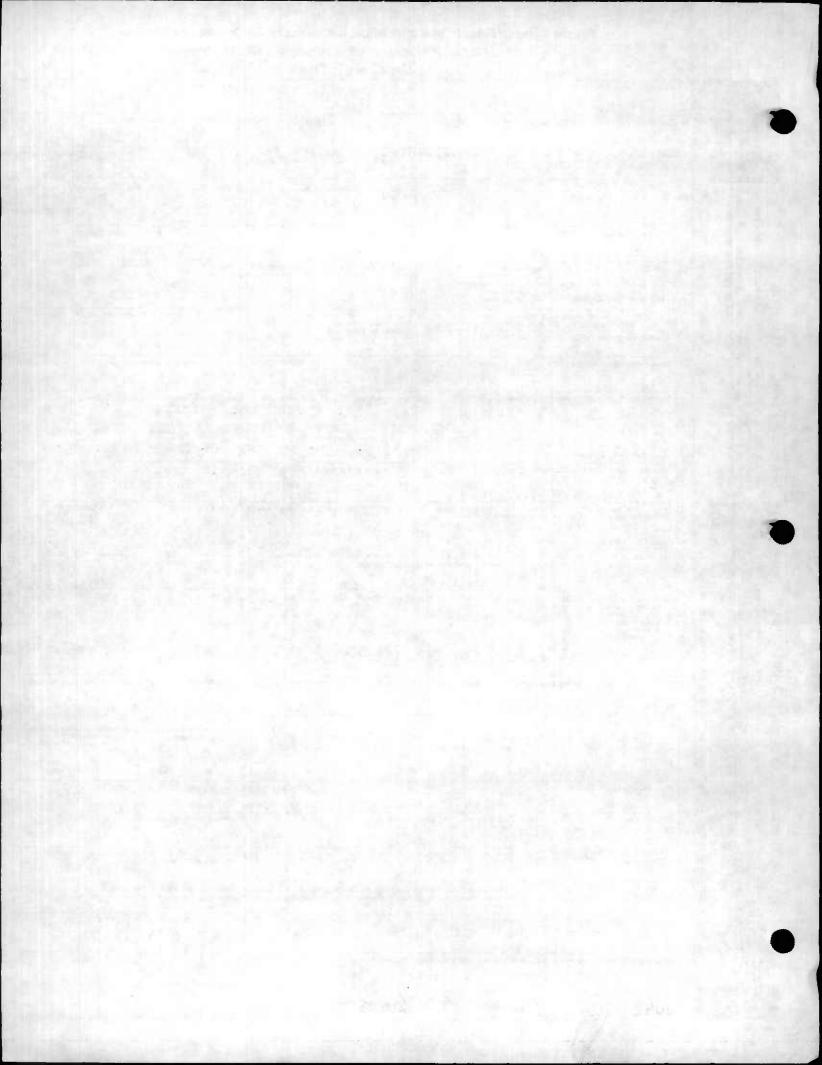
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31. Data filed (Month, Day, Year)

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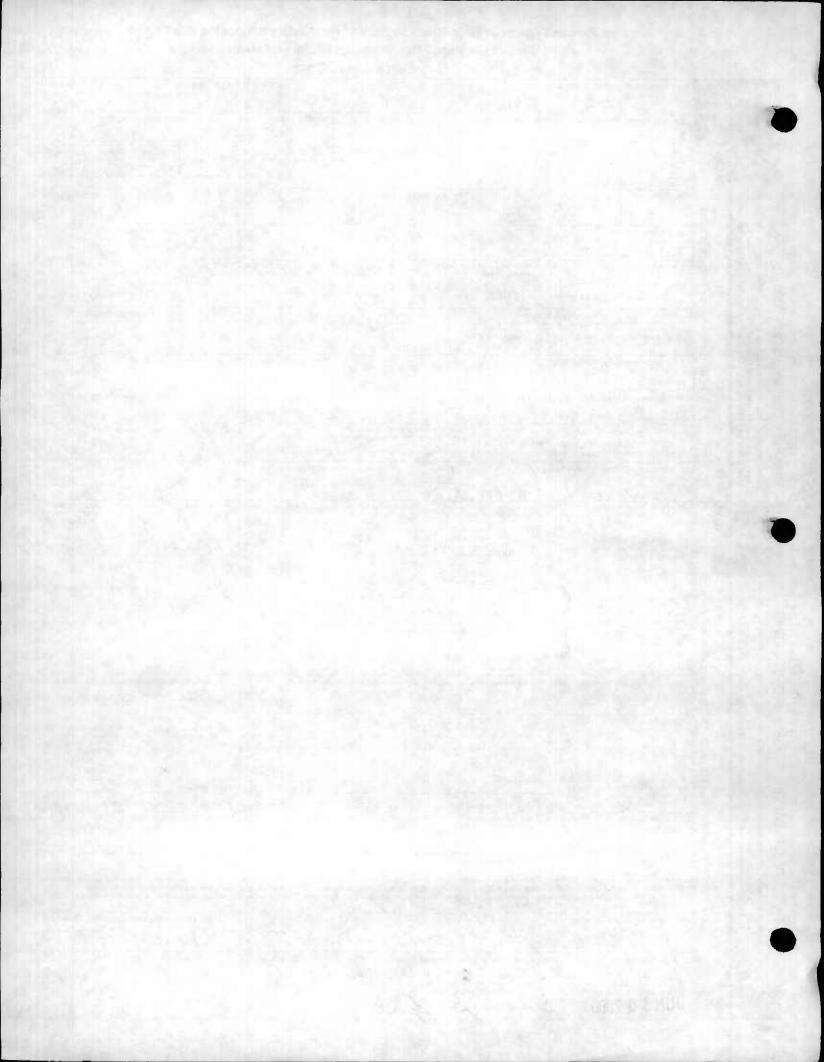
	Decedent's Name (First, Middle, La	act)	U	ertificate d	Douth	2. Date of Dea	Reg. No.	3. Time of Death
Physician	Minnie L					Month June	fg, 20°	
/Medical	4a Facility Name (If not institution, give				4b. City, Town, or I			
Examiner	Millennium of	•	Squar	e NH	Baltim		N N	
			(In yrs. last birthde					Birthplace (State or Fore
Funeral Director			65 Yrs.	Months Da		8. Dete of Birth (Month, Day 08-20	, Year) 0-34	Country) SC
* = 5	10a. State 10b. County		10c. City, Town or	Location	COUNTY BUILDING			10d. Inside City Limi
to to	MD NA		Baltim	ore				1√ Yes 2□N
or 28s-f s be notified Director	10a. Street and Number			10f. Zip Cod	0	10	10g. Citizen of Wha	t Country?
TO DE	122 N. Culver	Street		212	29		USA	
natural", or thema 23a or 28a-f abow dical Examiner must be notified at steed by Funeral Director	11. Marital Status  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent E- Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes;	ver in U,S. 1	3. Was Decedent If Yes, specify C	of Hispanic Origin? (Scuban, Mexican, Puert	pecify Yes or No- pa Rican, etc.)	14. Raca - / Black, V	American Indian, White, etc.
"natural", acceleration	15. Decedent's E	ducation	16a. De	pedent's Usual Oc	cupation	t les	16b. Kind of Busin	ess/Industry
	(Specify only highest grant   Elementery/Secondary (0-12)	ade completed)  College (1-4or 5+	(G life	DO NOT use re	cupation ne during most of wor tired)	king		
Hygiene. ther than	9th Grade	NA	′ Но	memaker			in hom	е
d other avant, p	17. Father's Name (First, Middle, Last	)		AL PROPERTY.	18. Mother's Ner	ne (First, Middle,	Maiden Sumame)	
	Henry Young	-Bey			Emma		ghes	
marke umarke	19a. Informant's Name/Relationship	(Type, Print)	19b. M	iling Address (Str	eet and Number or Ru	ral Route Numbe	r, City or Town, Sta	te, Zip Code) 212
27 le	Deborah Wi	llis	12	2 N. Cu	lver Str	eet Bal	timore,	Maryland
nent of He int: If Itam iry or oth	20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donetton 5 Other (Speci		20b. Place of Discemetery, Garri	sposition (Name or rematory or other SON For	placa) est VA C	Date em. 06-		or Town, Stata MD. Owings M
Department Important: If any injury o	21. Signature of Funeral Service Lica	Α	Ourr	22. Name and Ac				yland 212
de de de de de de de de de de de de de d	Bemand D	Johnson		WM.C.Ma	rch FH 1	101 E.	North A	
- 6	23a. Part1. Enter the disease, or con shock, or heert feilure. List only	polications that caused to one cause on each line	he death. Do not	enter the mode of	dying, such as cardia	or respiratory er	rest,	Approximate Interval Between
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/Medical	Immediate Cause (Final disease or condition resulting in death)	SEPS	SIS					ONE HON
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g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate		due to (or as a con	sequenca of):				
burles I	Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	· DEME	NTIA					TEN YET
physicians the bu	resulting in death) Lest	C	ue to (or as a con-	sequence of):				
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or us								
requires that the bean con- seen signed by the attendin- hould be detached for usa eted by Physician/N	Part II. Other significant conditions	contributing to death but	not resulting in th	underlying cause	given in Part I.	23b. Did t	obacco use contri	bute to the cause of dea
d by detac	NIABETES	MELLI	TUS			10	Yes 2000 3	Probably 4 Unkn
by by	1311100107	1,000						
been si should	HYPERTEN	SION					an autopsy 2 med? 2	4b. Were autopsy finding available prior to completion of cause
has b ge 2 sl								of death?
	SEIZURE	DISO	RDER			101	res 210 No	1 ☐ Yes 2 ☑No
page Com					26. Place of De	ath (Check only o	ne)	
E a a	25. Was case referred to medical	Hospital:	t 2 ER/Outpa	tient 3D DOA	Other: 4 Nursing I	lome 5 Resid	denca 6 Other	Specify)
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is certification director	axaminer? 1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	Year) 28b. Tim	V	TTOIR			
is certification director	axeminer?  1 Yes 2 No  27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 285. 1m		1 Yes 2 No			
is certification director	axaminer?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day)	ry - At home, farm,	М	1 ☐ Yes 2 ☐ No	28f. Location (S City or Tox	Street and Number on, State)	or Rural Route Number,
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negration of Autoritoring Propercient, 24 hours after death.  Funeral Director: After this certification by the funeral director detector death.  To Be edical Certification: To Be	axeminer?  1 Yes 2 No  27. Manner of Death 16 Natural 5 Pending investigation 2 Accident 5 Could not be determined.  2 Homicide Certifying Place Could not be determined.	28a. Date of Injury (Month, Day) 28e. Placa of Injury building, etc.  hysician: To the best of miner: On the basis of the second	ry - At home, farm, (Specify)  my knowledge, de examination and/o	M atreet, factory, off sath occurred at the investigation, in r	1 ☐ Yes 2 ☐ No ice	, and due to the during at the time,	m, State) cause(s) and mann	er as stated. I due to the cause(s)
nosponal or Attending Impacions 124 hours after death.  Funeral Director: After this certification letely filled in by the funeral director edical Certification: To Be	axeminer?  1 Yes 2 No  27. Manner of Death 16@Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not to determined  29a. Certifier (Check only one)  1 Yes 2 No  2 Pending investigation 4 Homicide  29a. Certifier 2 Medical Examples	28a. Date of Injury (Month, Day) 28e. Placa of Injury building, etc.  hysician: To the best of miner: On the basis of the second	ry - At home, farm, (Specify)  my knowledge, de examination and/o	M atreet, factory, off ath occurred at th investigation, in r	1 Yes 2 No ice e time, date and place ny opinion, death occu-	City or Tow , and due to the cirred at the time,	m, State) cause(s) and manndate and placa, and	er as stated. I due to the cause(s)
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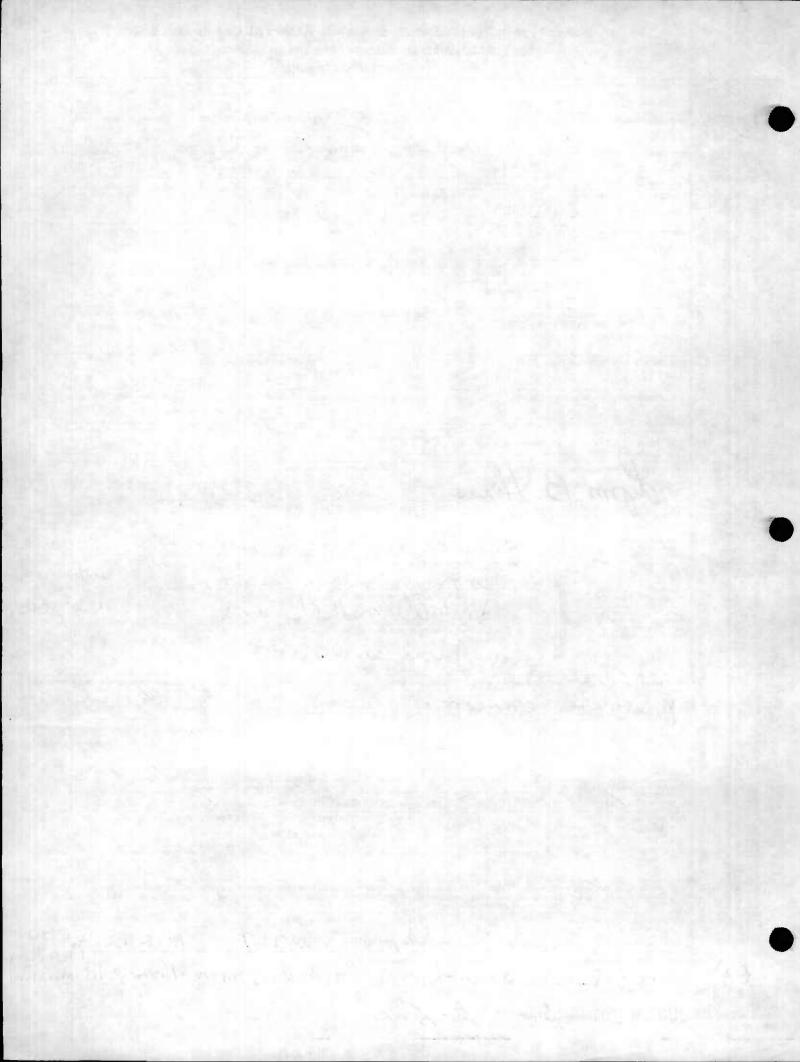
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State of Maryland / Department of Health and Mental Hygiene

		E. A. Jon 1 - 43	Certific	ate of Death	F	Reg. No.		
Physician	1. Decedent's Name (First, Middle, Las	et)	14-31	ALSO ENT	2. Date of Dea Month		Year 3	3. Time of Death
/Medical	Harriet	Wilhelm		1 20. 2		8, 200		8 AM
Examiner	4a Fscility Name (If not institution, give				or Location of Death	,		
	Gilchrist Cent			TO	WSON		9 Birtholac	
Funeral Director		□M 2只F 74	Mont	ths Days Houra M	Ain. 8. Date of Birtl (Month, Da)	3,1925		ce (Stata or Foraign v)
	Usual Residence of Decedant	10- 02	Town out assiss		12.00	7,720		2-21-
show of all	10a. Stata 10b. County		y, Town or Location					I. Inside City Limits  1 ☐ Yes 2 ☐ No
be notified	Maryland Bal	timore		hington Zip Coda		10g. Citizan of W		
	1218 W. Lake A	wanua	101.	21210		rog. Citizan or w	USA	
iner must Funeral	11. Marital Status	12. Was Decedent Ever in U,	S. 13. Was Do	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race	- American	
	1 □ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give	A Principal Street, St	specify Cuban, Mexican, Pu is ★☆No <i>Specify:</i>	uerto Rican, etc.)	Specify:	c, Whita, etc	
d by	3 Widowed 4 Divorced	Year or Dates:					WI	hite
leted	15. Decedent's Ed (Specify only highest grad	ucetion de completed)	16a. Decedent's t	Usual Occupation f work dona during most of t OT use retired)	working	16b. Kind of Bus	inass/Indus	stry
Complet	Elementary/Secondary (0-12)	Collega (1-4or 5+)		visor		Bell	A+1 > *	ntic
Be	17. Father's Name (First, Middle, Last)		Duper		Name (First, Middle,			TETE
9 0	Charles Dennis	on Stuller		Car	rie Stai	nes		
e .	19a. fnformant's Neme/Reletionship (7	ype, Print)	19b. Mailing Add	ress (Street and Number or	Rural Route Numbe	or, City or Town, S	Stata, Zip Co	ode)
P .	William Wilhel			. Lake Ave				MD 21210
10	20a. Mathod of Disposition		lace of Disposition emetery, crematory	(Name of or other place)	Dale	20c. Location - C	cily or Town imoni	
qury	4 □ Donation 5 □ Other (Specify			lley Mem.	Grdn 6/2	1/00 M	aryla	and
any i	21. Signature of Funeral Service Lices	()		e and Address of Facility ree-Henss-S	eitz Fun	eral H	ome.	Inc.
	Slavy X	Carpenle	3631	Falls Roa	d Baltim	ore. M.	aryla	and 21211
	23a. Partt. Enter the disease or comp shock, or heart failure. List only o	one cause of each line.	n. Do not enter the	mode or dying, such as cere	diac or respiratory ar	rast,	ln ln	Approximata Interval Between Onset and Death
sician edical	Immediate Cause (Final	0-10	00	career 1	1000 - 1		,	F. U
miner	disease or condition resulting in death)	Due to to	r as a consequence	concer of	WITK!	, C 4	1	3 months
je je		0 2001010	as a consequence	or,				
bunial-transit	Sequentially list conditions,	Due to (o	r as a consequence	of):	F- 45		1	
al E	Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury	c.						
2 2	thet initiated events resulting in death) Lest	Due to (or	r as a consequence	of):				
<b>2 3</b>		d						
detached for us	Part II. Other significant conditions co	antributing to doubt but not reco	thing in the underbri	no souse given in Part I	23h Did	obacco use con	tribute to th	he cause of death?
lached hysi	Part II. Other arginicant conditions co	Antiripating to death put not rest	atting in the underlyi	ng cause given in Part I.			1.	bly 4 Unknown
by P					_			,
cale has been signed by the attend, page 2 should be detached for us.  Completed by Physician/						an autopsy	availa	a autopsy findings able prior to
2 sh					20%		of dat	pletion of cause lath?
page 2					101	es 2 No	1 🗆 Y	Yes 2□ No
Be Scior	25. Was case referred to medicel examiner?	11- 21			Death (Check only o	ne)		,f
T die	1 Tes ZONO				ng Home 5 ☐ Resid			Hospice
After thi funeral funeral	27. Manner of Death  Natural 5 Pending  Accident invastigation	28a. Date of Injury (Month, Day Year)	28b. Time of fnjury	28c. fnjury at Work? 1 Yes 2 No	280. Dascribe r	now injury occurre	ю	
y the	3 Suicida 6 Could not be				28f. Location (S	Street and Numbe	er or Rural F	Route Number.
led in by the funeral Certification:	4 Homicide	building, atc. (Specify	()		City or Tow	vn, Stata)		
y filled	29a. Certifier (Certifying Phy	velcfan: To the best of my kno	wledga, daath occur	red at the tima, data and pl	aca, and due to tha	causa(s) and mar	nnar as state	led.
completely filled Medical Ce	one)	Iner: On the basis of examina and manner stated.	non and/or investiga	tion, in my opinion, death o	occurred at the time,	gata and place, a	nd due to th	na causa(s)
₩ O	29b. Signature and title of certifier	01		29c. License number		29d. Date signed		
	Monther	y Killy.	as	192902		I une l	J, do	300
	30. Name and address of person wire of	empleted cause of death (Item	23a) (Type, Print)	DOSDAS Rarles St	0 00		-	2215
	21 Data filed What Con Val	5 BME 670		MARIES ST	· Dalt	). Md.	21	20%
State Registrar	JUN 2 0 2000	32. Registrar's Signa	Ana V					
negistiai	A TOOD V		MINUTES					



		State	or iviaryland / i	Certificate of			eg. No.	
	Discolution	Decedent's Name (First, Middle, Last)				2. Date of Death	h Day Year	3. Time of Death
W.	Physician /Medical	Charles E.	Wegener			June 14		2:00 PM
	Examiner	4e Facility Name (If not institution, give street and n	umber)		4b. City, Town, or Le	ocation of Death	4c. County of Dea	th
		Home- 346 Rivers	7	10.11	Glen Be		Anne Art	
	Funeral Director	5. Social Security Number 6. Sex 215-01-7063 Lam 2 F	7. Age (In yrs. last bit	Yrs. Hunder 1 Year Months Deys		8. Date of Birth (Month, Dey, Aug. 13,	9. Bir Co ,1918 Ma:	thplace (State or Foreign puntry) ryland
	hend wa	10a. State 10b. County	10c. City, Tow	m or Location				10d. inside City Limits
	Mary Lesh tor	Maryland Anne Arundel	Pasa	dena				1 ☐ Yes 2X No
	er death with the Maryler fleme 23a or 28e+ show or mark is notified uneral Director	10e. Street and Number 346 Riverside Drive	De Danie	10f. Zip Code	122	10	og. Citizen of What Co USA	ountry?
21215-0020	or aft	Armed F	2 □ No	13. Was Decedent of If Yes, specify Cub. 1 □ Yes 25 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
5-0	ed within 72 ho ygiene. or than "natura rt, the Medical Completed	15. Decedent's Education (Specify only highest grade completed	16a	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation	ring	16b. Kind of Business	/Industry
121	within than than mole		(1-4or 5+)	life. DO NOT use retire	ed)			
		12		Silversmith		4000	Stieff Si	lver
Maryland	be fi	17. Father's Name (First, Middle, Last) William Wegener			18. Mother's Nam Mathilda			
2	d Men d Men marke	19a. Informant's Name/Reletionship (Type, Print)	101	o. Mailing Address (Stree		wage	nfuehr	Zin Carda)
Ma	trau	Bertha Wegener Wife						land 21122
e,	Heal Heal	20a. Method of Disposition	20b. Place 0	f Disposition (Name of	1		20c. Location - City or	
Baltimore	t. Peges tment of tant: If its sjury or o	1 X Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	n State	ry, crematory or other pla Grove Cemed	tery 6	5/19/00 E	Rayville,	Maryland
Bal	permit. Depent import eny in	21. Signature of Funeral Service Licensee	exas	Burgee-He	enss-Seitz	z Funeral	l Home Inc	a
	Physician	23. Part1. Enter the disease, or complications that shock, a heart failure. List only one cause on	ceused the death. Do each line.	not enter the mode of dyi	ing, such es cardiac	or respiratory erre	est, really tark	Approximate interval Between Onset and Deeth
ú	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	robable	myocar	idial,	wfare	estion	seconds
	<u> </u>	V		consequence of):	A.			ynoun
	physician end s the burlat-transit	D	Due to for age	consequence of):	2) orse	not		Yeu woons
68760,	ificate be execut 3 physician end es the burial-trar edical Exan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	Due to (or as a	consequence of):	eus) a	nd		year gens
Box 68	= 00		natura	& serve	escence			
	the death cert y the attendin sched for use	Pert II. Other significant conditions contributing to	death but not resulting i	n the underlying cause of	iven in Part i.	23b. Did to	bacco use contribute	a to the causa of death?
, P.O	that the red by the detache	prostrate CA.	weer			1 🗆 Ye	2 √No 3□P	robably 4 Unknown
Division of Vital Records,	The law requires thet the death cert care bas been signed by the attending page 2 should be detached for use Completed by Physician/M					24a. Was a	ned?	Were autopsy findings evailable prior to completion of ceuse of death?
<u>~</u>	nysician: The taw his certificate has to director, page 2 s To Be Compli					1□ Ye	s 2 No	1 □ Yes 2 □ No
/ita	entifica ector,	25. Wes cese referred to medical examiner?		-	26. Place of Deal	th (Check only on	e)	
Ž	Physician: this certificated director,	1 Yes 2 No Hospital: 1	Inpatient 2 ER/O	utpatient 3 DOA Ot	her: 4 Nursing Ho	ome 5 Aeside	nce 6 Other (Spe	ocify)
ion	Attending Pi or deeth. ector: After the by the funere iffication:	27. Manne/ of Death  1 DNeturel 5 Pending (Mo 2 Accident investigation		Time of 28c. Injury Wo	rry at ork? ] Yes 2 □ No	28d. Describe ho	w injury occurred	
Divis	tal or Attending P rs after deeth. el Director: After t led in by the funer Certification:	3 Suicide 6 Could not be determined 28e. Pla.	ce of Injury - At home, fa ding, etc. (Specify)	arm, street, factory, office		28f. Location (St. City or Town	reet and Number or R , State)	tural Route Number,
	Hospi 24 hou Funer stely fill	29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the and ma	e best of my knowledge basis of examination an nner stated.	e, death occurred at the ti d/or investigation, in my	ime, date and place, opinion, death occur	and due to the cared et the time, da	ause(s) and manner a ate and place, end du	s stated. e to the cause(s)
D	To the comple	29b. Signeture and title of certifier	Show to	29c. Licen	se number		9d. Dete signed (Mon	
		30. Name and address of person who completed ce	use of death (Item 23a)	(Type, Print)	12716		U	Pasadena
	10X/	Jerry Daniel S	Registrar's Signature	nis . 841	8 Balt	Imore	-ANNABI	Pasadena plis marylana
	State Registrar	JUN 2 0 2000 Genera	b 1	marka	Elly ( )	1211		



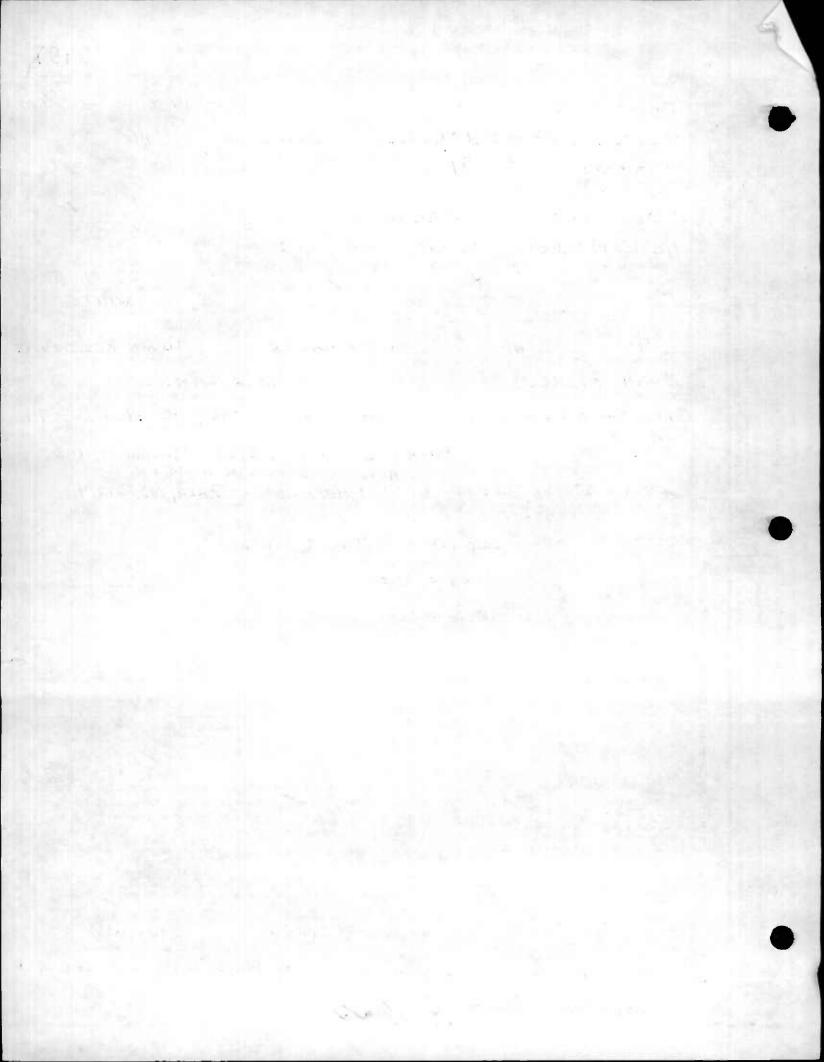
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Year **Physician** C. JUNE 18 2000 MADALINE WIEVARD /Medical c. County of Death 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CENTER BALTIMORE
If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) GENESIS-LONG GREEN NIA 7. Age (In yrs. last birthday).
Yrs. 5. Socief Security Number 6. Sex **Funeral** 1□M 20 F Months Days 216-32-6264 Usuel Residence of Decedent Director 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylar Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any highry or other treumatic event, the Madical Examiner must be notified at pine. 1 Yes 2 No BALTIMORE Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? SA 115 E. AVENUE MELROSE 21212 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Merried 2 ☐ Merried 1□ Yes 2□No Baltimore, Maryland 21215-0020 Specify à 3 ₩Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) TH OWN RESIDEVICE HOMEMAKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) PIERCE JOHN BESSIE LANGSTON 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) P.O. BOX 3074 FLORENCE, NIECE SC 29502-3074 CORRIE MAE STEWART 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) PARKINGOD CEMETERY 6/21/00 BALTIMORE, MD 22. Name and Address of Facility ALTENBURG FUNERAL HOME, P.A. 21. Signeture of Funeral Service Licenses 6009 HARFORD ROAD BALTO, MD 21214 Polent & attendres 410 D00002 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feilure. List only one clause on sech line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Dementie physician end s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, maine Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Onknown Records, þ or Attending Physician: The lew requires Completed 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Was en autopsy parlormed? 2 No 1 ☐ Yes 20 No certificate 1 Yes Division of Vital 25. Wes case referred to medical examiner?

1 Yes 2 No Be 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural 5 Pending 24 hours after death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only To the Within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) M.D. 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Enton A Finte 30F, Ball. MDZ121, 821 N. A HASHMI 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State Registrar JUN 2 0 2000

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 24b, per Phy. State of Maryland / Department of Health and Mental Hygiene 00

06/06/200	0,	Carroll County, v	vj1		Certificate of	Death		Reg. No.	U	13498
Physicia	_	1. Decedent's Name (First, Middle, Las		1.1.	+		2. Date of De Month	Day	Yeer	3. Tima of Death
/Medica	al	Walter W		trboo	asi	4b. City, Town, or I	May		-	9.00 pm
Examine	er	Carroll County G		pital		Westmin			arrol	1
Funeral		5. Social Security Number 6. Sa		(in yrs. last bi	irthday) If Under 1 Yaar	If Undar 24 Hrs.				ace (State or Foreign try)
Director		218-09-8248 Usual Rasidence of Decedant	M 2□ F	92	Yrs. Months Deys	Hours Min.	April	6,1908	New '	
hend was	1	10a. Stata 10b. County		10c. City, Tov	vn or Location				10	Dd. Inside City Limits
Man I	to	Maryland Carrol	1			Hampstead	f			1 ☐ Yes 2 No
r 28	Directo	10e. Street and Number		1 - 1	10f. Zip Coda	STATIST O		10g. Citizen of W	/hat Count	try?
th wil		406 Lees Mill Ro	ad			21074		US	SA	
72 hours after death with the Maryland natural', or frems 23s or 28s-f show dical Exercities must be notified at	by Funeral	11. Merital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yas 2 No If Yes, Give Year or Dates:		13. Was Decedent of It Yes, specify Cul		pecify Yas or No o Rican, etc.)	Specify.	e - Amarica k, White, a	
d 2 should be filed within 72 hours at the off Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exercitions.		15. Decedent's Ed	ucation	16a	. Decedent's Usual Occu	pation		16b. Kind of Bu	siness/Ind	ustry
within 7 iene. than 'n the Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+	-)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	ed) auring most of wor	rking			
filed within Hygiene. other than	5	6		A	utomotive Te	echnician		Martir	1 Mar	ietta
be file d othe event,	Be	17. Father's Name (First, Middle, Last)						, Meiden Sumem	Θ)	
should be nd Mental marked o	2	Fred Arbogast	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1				Kummel			
2 2 2 2		19a. Intormant's Name/Relationship (1 Wayne Arbogast,			b. Mailing Address (Stree 408 Lees Mil					Code)
Semil. Pages 1 an Department of Heel Important: if item 2 Iny injury or other		20a. Method of Disposition	D	20b. Piace cemate	of Disposition (Name of ary, crametory or other plants	ece)	Date	20c. Location -	City or To	wn, Stata
Pages nent of I ant: If the		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify		Hamp	stead Cemete	ery	5/31	Hampst	cead,	MD
permit. Pag Department Important: I any injury once.		21. Signature of Funaral Sarvice Licen	100	M00723	22. Nama and Addi	ress of Facility	Eline H	uneral H	- Home	
88 2 8 8		* Attur	WTL	Me	934 Sou	uth Main				074
		23a. Pent1. Entar tha disaese, or comp shock, or heart tailura. List only	plications that ceused	the death. Do	not antar the moda of dy	ring, such es cerdia	c or respiratory a	nrrøst,	1	Approximete Intarval Batween
Physician		onoun, or mount tanora. Else only	one custa on cust mi							Onset and Death
/Medical		Immediate Cause (Final disaase or condition	P	neuw	IDNIA					
Examiner		resulting in daath)			consequence of):			1-1-15		1 3 7 6
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deeth certificate be executed e attending physician and of for use as the bunlatifiansit	Examine	Sequentially list conditions,	C	Due to (or as e	consequence of):					
ficete be expression as the buria		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury	c	Dew	ientia					
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onding pluse as 1	5		d					C. 4.11.5		
attendin	Physician/	Death Other death and and the	and the sale of a sale decided		1- ab	to an in Daniel	non Did	Andreas sind and	andhusa sa	the cause of death
the sche	hys	Pert II. Other significant conditions co	minibuting to death but	t not resulting	in the underlying ceuse g	iven in Part I.			3 Prob	1.
E X D	by P		10000					100 2010	0   1100	
lew requires that es been signed b 2 should be deta	8							an autopsy		ara autopsy findings ailabla prior to
sician: The lew requires the certificate has been signe rector, page 2 should be to	Set						pen	omed?	cor	mpletion of cause death?
The lew ate hes page 2	Completed						10	Yes 2 No	-4	2X) No
certificate	0	25. Was cese retarred to medical	No. 3 1 197			26. Place of De	ath (Check only	-		
F 40 T3	0	examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 ER/O	Suppatient 3 DOA	Wher:	-	idence 6 □Oth	er (Specifi	y)
erthis	ü	27. Manner of Death	28a. Date of Injury (Month, Dey	/ 28b.	Time of lnjury 28c. Inj	ury at	28d. Describe	how injury occur	red	1-1-1-1
Attending in death.	atio	1 Natural 5 Pending investigation		, ,		Yes 2□No	E			
l or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be detarmined	28a. Plece of Inju- building, atc.	ry - At home, f (Specify)	arm, street, fectory, office	•		(Street end Numb wn, Stete)	er or Rura	l Routa Number,
oral oral	2	20-0-4								
To the Hospital or / within 24 hours after To the Funeral Dire completely filled in the formal or its completely filled in the formal o	edical			examination a	e, death occurred at the nd/or investigation, in my					
To the Within 2 To the comple	¥	29b. Signature and title of certifies			29c. Licer	nse number		29d. Date signe	d (Month, i	Dey, Year)
F > F 0		Virgin Vida	YMY	ouse &	Duca	D3899	2	5/28	00	
	-	30. Nema end address of person where	ompleted causa of de	ath (Item 23a)	(Type, Print) 200	) Memoria				r
		Henry (	ldermo	Con	rroll Cour		eval Ho		MD	21157
Stat	e	31. Date filed (Month, Day, Year)	32. Ragistra	r's Signatura	/ /	7				
Registra	ır	JUN 0 6 2	2000	neva	D Apa	chs				A State

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State of Maryland / Department of Health and Mental Hygiene 00 19499

1. Decembers Name (Pirt, Modes, Last)   2. Delie of Death Modes)   7. 2000				eruncate	e of Deat	T I	Re	g. No.		9495
Subtribution Antonio Artispe  # Fally Name   Four interface by the rest and running   \$0.000   \$0.000   \$0.000   \$0.000   \$0.0000   \$0.0000   \$0.0000   \$0.0000   \$0.0000   \$0.00000   \$0.000000   \$0.000000   \$0.000000   \$0.000000   \$0.000000   \$0.0000000   \$0.0000000   \$0.00000000   \$0.000000000   \$0.0000000000	. Decedent's Neme (First, Middle, La	st)				2.			Year	3. Time of De
46. Facility Name of not nesticate, you share and number?  50. Suburban Hospital  5. Souls South Number  5. Souls South Number  5. Souls South Number  5. Souls South Number  5. Souls South Number  5. Souls South Number  5. Souls South Number  5. Souls South Number  5. Souls South Number  5. Souls South Number  5. Souls South Number  5. Souls South Number  5. Souls South Number  5. Souls South Number  5. South N	Guillermo Antoni	o Arispe				J		*	1 041	7:00
\$ Social Scorety Numbers \$78 = 96 = 392 \$2					4b. City,			4c. County	of Death	
\$ Social	Suburban Hospital	1			Bethe	esda		Monts	gomery	7
Use   Part   Incomment   Inc						er 24 Hrs. 8.	Dete of Birth	Year)	9. Birthpla	ace (State or F
106. State   109. Courty   100. Courty   100. College   100. State and Number   107. State and Numbe	578-96-3922	LXM 2LIF	85 Yrs.	Months	Days	F	eb 6,	1915	Peru	· y/
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11. Marias Satura	0e. Street and Number	1000		10f. Zip	Code		10	g. Citizen ot	What Count	ry?
Name   Married   Name	10250 Westlake Dr:	ive		208	17		US	SA		
Continued   Cont	1. Marital Status	12. Was Decedent Ev	ver in U,S. 1	3. Was Decede	ent of Hispanic (	Origin? (Specif	y Yes or No-			
Securitary is conditions conditions contributing to death but not resulting in the underlying cause given in Pant.	1 Never Merried Married	1 ☐ Yes 2X No								
Continued   Cont	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1LAYes 2	ZLI NO Speci	y: Peru	vian	Specify	Whit	ce
Security   Security	15. Decedent's Ec	ducation					1	6b. Kind of B	usiness/Indi	ustry
Accountant  Accounting  17. Fether's Name (First, Middle, Maxiells Summer)  Jose Manuel Arispe  Jesus Maria Meneses de Arispe  19a. Informant's Name-Relationship (Type, Print)  Lisabel Arispe  19b. Melling Address (Street and Number or Paral Rouse Number, City or Town, Stele, Zp Code)  11. Subel Arispe  102.50 Westlake Drive , Bethesda, MD 20817  Can Method of Disposition  1. Kiburel 2 Disnaminos 3 Demoval from Stele  4. Disnaminos 3 Demoval from Stele  4. Disnaminos 3 Demoval from Stele  4. Disnaminos 3 Demoval from Stele  4. Disnaminos 3 Demoval from Stele  4. Disnaminos 3 Demoval from Stele  4. Disnaminos 3 Demoval from Stele  4. Disnaminos 3 Demoval from Stele  4. Disnaminos 3 Demoval from Stele  4. Disnaminos 3 Demoval from Stele  4. Disnaminos 3 Demoval from Stele  4. Disnaminos 3 Demoval from Stele  5. Prancis J. Collins Funeral Home, Inc.,  5. Duniversity Blvd. W. Silver Spring, MD  22. Name and Address of Facility  Francis J. Collins Funeral Home, Inc.,  5. Duniversity Blvd. W. Silver Spring, MD  22. Name and Address of Facility  Francis J. Collins Funeral Home, Inc.,  5. Duniversity Blvd. W. Silver Spring, MD  22. Name and Address of Facility  Francis J. Collins Funeral Home, Inc.,  5. Duniversity Blvd. W. Silver Spring, MD  22. Name and Address of Facility  Francis J. Collins Funeral Home, Inc.,  5. Duniversity Blvd. W. Silver Spring, MD  22. Name and Address of Facility  Francis J. Collins Funeral Home, Inc.,  5. Duniversity Blvd. W. Silver Spring, MD  24. West and population of Address of Facility  Francis J. Collins Funeral Home, Inc.,  5. Duniversity Blvd. W. Silver Spring, MD  24. West and population of Address of Facility  Francis J. Duniversity Blvd. W. Silver Spring, MD  24. West and population of Address of Facility  Francis J. Duniversity Blvd. W. Silver Spring, MD  24. West and and Desire Market Spring, MD  24. West and and Desire Market Spring, MD  24. West and and Desire Market Spring, MD  24. West and and Desire Market Spring, MD  24. West and and Desire Market Spring, MD  25. Distance			life	e. DO NOT use	k done during m se retired)	ost of working				
Jesus Maria Meneses de Arispe  19a. Informant's Nama-Relationship (Type, Print)  19b. Meiling Address (Street and Number or Rural Route Number. City or Town. Stete. Zp Code)  13abel Arispe / Wife  10250 Westlake Drive, Bethesda, MD 20817  208. Method of biopsosition  1/ (Supposition) Tamerous I considered of the Composition of Supposition (Prince) Softwer (Specific)  21. Signifium of Funeral Service Licensee  22a. Part Errist the disease, or complicatives their caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, second interest on the cause of the	Listing in the state of the sta			untant				Account	ting	
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19a. Informant's Name/Relationship (Type, Print)  19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1 Sabe 1 Arispe   Wife   10250 West1ake Drive   Bethesda, MD 20817  20b. Netword of Disposition (Name)  1 Surver   Service   Consense   20b. Place of Disposition (Name)  1 Surver   Service   Consense   20b. Place of Disposition (Name)  21. Signifully of Funeral Service   Connece   20b. Place of Disposition (Name)  22 Name and Address of Facility   Francis J. Collins Funeral Home, Inc.   500 University Blvd.   W, Silver Spring, MD 20   20b. Place of Heaven   1000   20b. Place of Heaven	Iose Manuel Arten	0			Inci	ic Mari	a Mana	202 40	Arice	20
Sabel Arispe   Wife   10250 Westlake Drive			19b. Me	eiling Address						
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1 (Allowie) 2   Cremellon 3   Demondations of Other (Specify)    21. Significant of Financial Service Licensee   22. Nems and Address of Facility   Francis J. Collins Funeral Home, Inc.    22a. Part   Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,   Approximate short of reheart feature. List only one cause on each ine.    1. Collins Funeral Home, Inc.   500 University Blvd.   W. Silver Spring, MD 21    23a. Part   Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,   Individual Services   Constitution   Constitutio		wire								
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Francis J. Collins Funeral Home, Inc.  500 University Blvd., W, Silver Spring, MD 2/  23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate fineral conditions contributions of the cause of each line.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  1   Vee 2   No 3   Probably 4& University of the contribution of death but not resulting in the underfying cause given in Part I.  24a. Was an autopsy printing available prior to completion of cause of death?  1   Vee 2   No 3   Probably 4& University of the contribution of the cause of death?  25b. Was case referred to medical examiner?  27b. Was case referred to medical examiner.  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Death (Check only one)  27b. Place of Dea	4 Donation 5 Other (Specify	y)	Gate of	Heave	n Cemete	ery   6/	9/00 8	Silver	Sprin	ng, MD
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Immediate Cause (Finel disease or condition resulting in death)    Sequentially list conditions contribute to the cause (Space)	I of I	Lund		Francis	S J. Co.	Llins F	uneral	Home,	inc.	
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Duilding, etc. (Specify)  29a. Certifier Check only  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.  2 Nedical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated.  29b. Signature and little of certifier  29c. License number  29d. Dete signed (Month, Day, Year)  29d. Name and address of person who completed cause of death (Item 23e) (Type, Print)	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Jause (Disease or Injury het initiated events esulting in death) Last  Part II. Other eignificant conditions of the conditions of the camping of the conditions of the camping of th	b. Rundle Do C. Do d. Do C. Do C. Do C. Do Contributing to death but Do Contributing to death Do Contributing	ue to (or as a consult to (or a)))).	sequence of): sequence of): sequence of): sequence of): sequence of): sequence of): sequence of): sequence of): sequence of): sequence of):	26. Pia A Other: 4	ca of Death (C	1 Ve	autopsy ed?	antribute to 3 Prob.  24b. We ava con ot d	the cause of cabby 4 Universe of the cause of cabby 4 Universe of the cause of the cause of the cause of the cabby 1 Yes 2 No.
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